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MILITARY MEDICINE

ORIGINAL ARTICLES

Authors alone are responsible for opinions expressed in their contributions

Some Recent Steps in Meeting Our Nursing Needs

By

LUCILE P. LEONE

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THE increasing number of hospitals that are being built, expanding programs in both public and private health agencies, and changing emphasis on the types of nursing care needed are putting heavy demands on a nurse supply that is already stretched too thin for safety. Even with increases in the school-age population—result of the wartime baby boom—and the anticipated increases in the number of future nursing students, there still will be far fewer nurses than necessary to meet future demands.

What is the reason for this nurse shortage? The answer may be as much a qualitative one as a quantitative one. If it were merely a question of recruiting larger numbers of young women and men into the field, the solution, while not simple, would yield to defined attack. Considerably more action must yet be taken to find out why the shortages exist; to determine whether our present nurse supplies are being utilized to the best advantage, or whether more auxiliary personnel, trained to take over housekeeping and non-nursing duties, will help to solve this dilemma.

Behind all this is a factor which is much more fundamental and is perhaps the greatest hurdle in the way of efforts to improve nursing service. While there are nurses prepared for leadership positions in administration, supervision, and teaching, the number is inadequate. Although some increases have been noted in the numbers of professional nurses employed in recent years, the number of administrators and supervisors in proportion to the total staff has decreased. Many nursing schools have indicated that inability to increase their teaching staff is the only barrier to increasing their enrollments. Current trends in graduate nurse education show that, despite the obvious opportunities for well-trained persons in top positions, too few nurses are graduating from these advanced training programs and the need will continue to go unmet unless something is done.

During the war years the efforts of the Federal government and other groups enlarged the supply of graduate nurses, and provided a large number of scholarships for special study. The G. I. Bill of Rights program also aided nurses to prepare themselves for advanced positions. Even with this good start far too few nurses now in leadership positions have had the kind of training needed to prepare them for the multiplicity of responsibilities they must face. Only about 55 percent of the professional nurses who are teachers hold college degrees, an acknowledged minimum qualification for teachers in high school and certainly in a professional school conducted at a college level of instruction whether the program it offers leads to a diploma or a degree. An even smaller number of nursing supervisors and administrators (one-fifth and one-half

respectively) have completed an educational program specified for their preparation.

The nurse, like a great many people in other professions seeking education at higher levels, is faced with a financial problem. Indeed, her problem may be even greater because of the generally lower salary out of which she must pay for her education. Three-fourths of the nurses enrolled for graduate study are going to school part time. Exact data are not available on all of these students, but it can be assumed that many part-time enrollees are actually working full-time and taking one or two courses in the evening. Others undoubtedly must interrupt their studies from time to time to return to full-time employment. Under these circumstances the period of study is prolonged for many years. This is neither good for the nurse, who is straining her physical resources to undertake what amounts to two jobs, nor to society, which must wait so much longer before the nurse can make her full contribution.

Unfortunately, little has been done in the past to approach realistically the problem of higher education for nursing. Some scholarship aid is available through private organizations, though hardly enough to scratch the surface.

This year, however, aided by the efforts of the professional nursing and hospital organizations, a step toward alleviating this critical nursing need has been taken. In the last days of its second session, the 84th Congress passed the Health Amendments Act of 1956, which President Eisenhower signed as Public Law 911 on August 2. Title II of this Act establishes a three-year program to provide traineeships to prepare graduate nurses for positions in administration, supervision, and teaching. An appropriation of $2 million was authorized for the first year, ending June 30, 1957. The traineeships are to be awarded through grants to institutions, rather than directly to individuals. The institution will use its own established admission policies in selecting candidates for traineeships.

The traineeship includes tuition and fees, an allowance for living expenses, an allowance for dependents, and travel to the training institution. The program is being administered by the Division of Nursing Resources, Public Health Service, Department of Health, Education, and Welfare. An expert advisory committee is called for in the law, to advise on policies and standards in regard to the operation of the program.

The new program, now called the Professional Nurse Traineeship Program, was put into motion immediately. Realizing the importance of this legislation, many of the committee members called to advise on initiation of the program interrupted or cut short their vacations in order to serve. The 12-member committee represented not only the givers and users of nursing service—educators, hospital administrators, directors of nursing service, representatives of professional groups—but also represented every region of the United States.

At the same time that the advisory group was meeting to discuss the nurse traineeship program, another committee was meeting to consider another section of Public Law 911. Title I authorizes a similar program to provide traineeships for specialized training for public health personnel. Under this Title funds are available for physicians, nurses, engineers, and other professional public health workers to study for their public health specialties. In the case of nurses, the traineeships permit preparation for staff level (beginning) positions only. Public health nurses who wish training in administration, supervision or teaching are eligible to apply for traineeships under Title II.

At this writing it appears that all the available traineeships are being applied for, and many schools have asked for additional traineeships to aid other eligible and deserving students. Many of these students receiving traineeships were part-time enrollees who will now be able to carry a full schedule. Others are nurses who will be able to finish their work in a semester's time and thus be able to take leadership positions early next year.

Another step toward improving nursing

service is the Nursing Research and Fellowship Program, also guided by the Division of Nursing Resources. This program was set up in July 1955, to stimulate research in problems affecting nursing service and in methods of improving patient care. Establishment of this program marked the first time that Federal funds had been earmarked specifically for research in the field of nursing. Heretofore, such money as was available came from general funds for aiding medical and scientific studies.

For the first year of operation, ending June 30, 1956, Congress appropriated $625,000, of which $500,000 was set aside for the research program, and $125,000 for the accompanying fellowship program which is designed to aid nurses in learning techniques of research. In this first year 20 research projects have been approved by the National Advisory Health Council, including research on various aspects of nurse-patient relationships; on why young women select nursing as a career, and on ways of improving nursing services for patients and nursing schools.

Under the fellowship program 27 full-time fellowships and 62 part-time fellowships in 16 universities were awarded. The program is being continued this year with an appropriation of $700,000. About $120,000 of this will be available for new projects; the remainder will be used to carry over studies now in process.

It is not expected that these two programs will ease all our nursing problems overnight. Indeed the full impact will not be known for several years. These funds, both for traineeships and research, are only a beginning and the demand for them that has already been demonstrated clearly points to the areas where the answer to nursing shortages may lie.

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The Supervisory Process in Administration

By

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ADMINISTRATION of nursing service has always presented complex and difficult problems because of the number of disciplines having to do with nursing but not being an actual part of it. At the Clinical Center of the National Institutes of Health the administration of nursing services is even more complex as nursing must be provided for six different medical research institutes, each having different needs and different routines. In order to illustrate these differences as they affect the nursing supervisory processes in this particular setting, we have selected two nursing services in which the same basic principles have been applied in slightly different ways.

At the Clinical Center, there is a Central Nursing Office, under the direction of a Chief Nurse, which is responsible for all of the details of administering the nursing services provided for the six institutes. (A seventh, National Institute for Dental Research, has a few hospital beds within one of the nursing units of the National Institute of Arthritis and Metabolic Diseases.) Through the Central Nursing Office, nurses are employed and assigned to one of six nursing services, Cancer, Heart, Arthritis and Metabolic Diseases, Infectious Diseases, Neurology and Blindness or Psychiatry. Each nursing service has a designated chief who is responsible for supervising nursing care to patients assigned to the particular institute with which she is associated. Under this plan, nursing is a department in the Clinical Center central patient care organization and is responsible for providing nursing service to each institute requiring inpatient care. In addition, there is an Admissions and Follow-up Service (out-patient) requiring nurses and nursing, as well as the Operating Rooms where surgery for all institutes is performed.

The Chief of each nursing service is directly responsible to the Chief, Department of Nursing, and is authorized to evaluate, organize and plan for nursing service according to the needs of the patients being studied by the institute concerned.

In the Neurological Nursing Service the needs of both patients and doctors differ from those of other nursing services. Because of the nature of neurological disturbances the emotional aspects of these patients can never be overlooked. In order that nurses may be able to meet the needs of these patients they must function in an environment as free from tension as possible and with a sense of security in the working situation.

Since the Neurological Nursing Service and the Psychiatric Nursing Service have been selected to point up the similarity in the application of basic principles it is well to review the general philosophy in relation to the supervisory process in the administrative structure.

We believe that the feeling tone of an organization is established at the top level of administrative authority and is reflected on down through the ranks of workers. If that tone is one of understanding, sympathy and cooperation patients will be less anxious, personnel will be more secure and assistance to the research under way will be more effective. This does not imply a lack of discipline or a disregard of established routines. Instead, it emphasizes, through orientation of personnel, the need for discipline, be it individual or group, and also the need for a well established pattern of operation in order to accomplish the most good for all.

In dealing with neurological patients it is recognized that a positive approach obtains better results than one of vacillation and uncertainty. Thus, it is important that such an approach be understood and used,

not only by the supervisory staff but by the staff directly responsible for neurological nursing care of patients. If the supervisory relationships reflect an understanding of personnel needs we believe personnel will in turn reflect an understanding of patient needs.

In working with neurological patients it is important that the staff as a whole has a good understanding of total patient care and the necessity for a uniform approach to satisfying their needs. One of the problems, then, is the interpretation of nursing functions through staff activity.

Neurological patients react to a tense environment just the same as other patients but perhaps in a manner somewhat more evident. It is important that all members of the nursing team recognize how, as a group, they can maintain an environment which will provide for patient recovery and security. The group concept is important, as one individual working contrary to an agreed upon approach can disrupt the total program.

The problem then resolves itself into how can group unity be established both theoretically and practically. Our observations support our belief, that if the group can be made to realize the importance of joint planning and free discussion that group decisions will be sound and group action therapeutic.

Administratively it is important that supervisory personnel recognize and encourage a working environment that will be conducive to the aforementioned items. Thus, the supervisory responsibility becomes that of interpreting staff needs and providing the means and climate in which the staff group can interpret, plan, and execute nursing care.

Communications are perhaps the most important aspect of this concept. Nursing care involves both physical and emotional needs. In order to obtain adequate results in both phases the staff must know what is being sought and the best methods for obtaining the results desired. If all staff members participate in planning and if controversial matters are freely discussed, it is believed that a wholehearted acceptance is more likely than if supervisory decision is imposed. There are times when a supervisory decision is needed, but if the staff group is properly oriented to work within the limits set for it, the necessity for supervisory decision is recognized and accepted the few times it is needed.

In transmitting information, suggestions, routines and ideas from the supervisory level to the staff level and then on to patients, both formal and informal channels are used. The formal channels include:

(1) Morning, evening and night reports which are written but verbally elaborated when discussing content.

(2) Daily team meeting where all patients are reviewed in relation to treatments administered, emotional tone and anticipated activity.

(3) A weekly conference session for all nursing personnel where neurological diseases and the research methods related to those diseases are discussed.

(4) A planned orientation program on a designated nursing unit for all new nursing personnel where individual aptitudes and abilities are evaluated and the length of training time determined on an individual basis.

(5) A staff organization where categories of personnel meet in individual groups for the purpose of handling group needs and problems. When problems seem to involve more than one group a joint meeting may be requested but such a request is initiated within the group itself. For example, the staff nurses may wish to clarify their relationship with team leaders and a joint meeting of the two groups result.

(6) Supervisory personnel meet every two weeks to discuss problems and exchange information.

The informal method is used every day in patient-staff relationships where informal

discussions and casual conversations are encouraged. Interpretation of patient mood, complaints and interests by nursing personnel is considered to be part of the daily routine.

Supervisory-staff contacts are frequent, informal and usually friendly. Nursing personnel are encouraged to discuss those elements of the working situation which cause distress or unrest. Explanation of purpose or group welfare over individual welfare serves on many occasions to lessen irritation and tension. Suggestions for improvement of routines are encouraged with the hope that group interest will be sustained and strengthened.

The goal in the assignment of team members is to utilize each individual's ability as effectively as possible. Since team members participate in planning assignments, a feeling of mutual respect is engendered and results in pride of accomplishment.

In the Psychiatric Nursing Service, the supervisory pattern differs, although also established on the basic concept that feeling tone is reflected from the top down. This Service shares with neurology the concept that an understanding of differences in personalities, both patient and staff, is essential to achieving maximum cooperation.

The Psychiatric Nursing Service has as its philosophy the theory that mental illness is, for the most part, a disorder which manifests itself through severe difficulties in living with people. The purpose of hospitalization, then, is to provide a place where patients may learn to live more effectively with other people. The goal of the psychiatric nursing administration is to provide a nursing staff that will in all areas of nursing care, allow patients such experiences as will contribute to the purpose of hospitalization. It is believed that the experiences patients have in the hospital are the same as (or directly reflect) the experiences of the staff. The experiences of the staff directly reflect the nursing administration. Thus, it is assumed that if the administration sets rigid and arbitrary limits for the staff, the staff will set rigid and arbitrary limits for patients.

Here, also, communication is an important aspect of supervisory procedure. It is of primary significance in the care of the mentally ill in whom it seems that some defect in the ability to communicate is an almost characteristic symptom. In order to accomplish improved communications we have:

(1) Established formal lines of communication, both verbal and written, that will facilitate the transmission of information and ideas essential to effective operation. This includes all structured situations that are developed both for operational and educational purposes—the orientation program, change of shift reports, nursing unit conferences, problem-solving seminars, and nursing notes.
(2) Regularly scheduled times for reporting and discussion.
(3) Identified and explored areas in which communication breaks down, distortions appear or conflicting messages are received.
(4) Become critically aware of the importance of the sort of message that is transmitted informally in a psychiatric setting. This includes not only nonverbal transmission of ideas and feelings, but also the type of behavior sometimes called "acting out," observed in both patients and staff, (such as destruction of property, absenteeism, accidents, etc.).

In contrast to the neurological nursing situations the nursing personnel "live" with the patient for the entire tour of duty on the Psychiatric Nursing Service. Nursing personnel must develop skill in relating simultaneously to many individuals of varying degrees of illness and meet the needs of all. Thus, from a supervisory point of view, it is important that considerable time is given to individual staff members. It is important that nursing personnel are able to make quick decisions and that the individual assuming this responsibility is secure in the

work situation which is governed to a large extent by supervisory attitude.

The supervisory process described in this paper is focused on the aim of creating a social climate in which personnel can function at a level commensurate with their abilities and with respect for the interests and welfare of both patients and co-workers. To be effective there must be an understanding of the "why" in all situations and an appreciation of the limits which need to be set by the supervisory staff.

Staff Nurses Are More Than Bedside Nurses

By
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A COMMON problem exists today in any hospital where the nursing staff is composed of a majority of nursing assistants and a minority of nurses.

The heart of the problem lies in the unpreparedness of the average staff nurse to provide effective teaching and supervision of non-professional personnel in the continuous work situation. Current pressures in nursing economics make these functions the responsibility of the staff nurse.

SPECIFIC PROBLEM

This problem became acutely evident to us in October 1953 when the West Roxbury Veterans Administration Hospital reopened with a preponderance of new help. The instructors, supervisors, and head nurses could not closely guide so many new employees on large wards simultaneously. Therefore, new staff nurses had to assume this responsibility in addition to their customary assignments of patient care in an unfamiliar situation.

Though they met the emergency nobly, several inadequacies were obvious. Many nurses were reluctant to correct poor work of the men. They feared that their suggestions would be resented. A few nurses said they did not know how to teach or to supervise—that was the work of specialists. They complained that they did not know what the men were taught in the classroom. Frequently the nurses neglected to determine the trainee's progress and assigned duties beyond his capabilities. (As a safeguard, each man was taught to use this stock phrase, "I'll be glad to do it if you'll show me how.")

A very common difficulty was the nurses' use of medical terminology and hospital jargon without reasonable clarification. They paid little attention to the individuality of the trainee and ignored his need for recognition and guidance. In general, their attitude was, "let me do my own work, I don't want to be bothered with checking someone else."

There were three main problem areas. The most important was one of attitude. Many nurses felt that duties of teaching and supervising non-professional personnel were beyond the scope of the staff nurse. Stemming from this attitude were deficiencies of communication skills and interpersonal relationships.

Immediate measures were taken to remedy the situation, but, more important, a long term program was initiated. Through group conferences and individual discussions, the problem was explored. Past experience, current literature and future trends were considered. Representative members of all concerned groups were involved in the analysis and helped formulate the solution.

In defining the objectives, thoughts were not limited to our hospital situation alone. Two stimulating sources were Dr. Esther Lucille Brown's "Nursing in the Future" which many of us re-read and discussed, and comments of Milton Lesnick, legal consultant for the American Nurses Association. Frequently quoted was his statement, "The value of the Professional Nurse over and above that of the Practical Nurse or Hospital Aide lies in her ability to teach, supervise, do administration and research." When this definition permeated the thinking of the staff the goal became obvious. The fundamental method selected to achieve this goal was "learning by doing" rather than by "preaching." And the "doing" was

planned so that it would graduate from the simple to the complex. This goal and method were integrated into our varied programs.

The stated problem concerns the ability of the average staff nurse to provide effective teaching and supervision to nursing assistants in the work situation. Therefore, I shall discuss only those parts of our program which bear directly on this subject. Other phases of the total program (development of administration and research abilities) exerted a positive influence on the nurse-assistant relationship.

Nurse orientation had always included thorough information on the Nursing Assistants Training Program, with emphasis on sustained supervision of coordinated ward experience. To arouse the staff nurse to her increased responsibilities, nursing trends were traced during the past 20 years and projected for the next 20 years. I am sure that some of our older staff nurses were jolted by fear as we discussed the trend toward more collegiate schools of nursing, more practical nurse schools, and fewer 3 year schools. They could visualize themselves as neither fish nor fowl. It was a case of developing to professional nurse stature or regressing to practical nurse level. They saw the light! With their attitude influenced, the "doing method" was applied. Each staff nurse was given full responsibility for teaching four basic classes to new men on the ward. These classes were: Ward Orientation, Bedmaking, Care of Environment, and Diet Service.

By the time each nurse completed this assignment, she was aware of her assistant as an individual, and was more sympathetic to his problems of adjustment. She knew his aptitudes and his weaknesses. She learned that her time was well spent in teaching by the man's subsequent improved production and performance.

A natural outcome of this teacher-student activity was improved rapport and cooperation. The nursing assistant went to the staff nurse with his problems and the nurse could be sure her suggestion or criticism was wanted. She reminded the assistant to get to class on time, kept informed on his progress, and carefully assigned suitable ward experience with intelligent supervision. Teaching, since she was now a part of it, was no longer an "Ivory Tower" beyond her comprehension or interest. In fact, we do not often use the word "teach." We simply say, "Will you show him how to do it, then keep an eye on him in case he needs help?"

Somewhere, that term "teach" has acquired an awesome connotation. Many nurses do not realize that they teach unintentionally whenever they are observed by others. They teach by their actions, their omissions, their comments, and the withholding of criticism. If they fail to correct a slipshod or dangerous practice, then the act is interpreted as being condoned. And so far as human feelings are concerned, constructive criticism is preferred to being ignored. These basic truths were stated and restated in guiding our nurses in their first real efforts in teaching.

The Ward Conference program was also changed to conform to our new policy. Previous conferences had been most frequently given by doctors on subjects requested by nurses. The topic was helpful but nurses were passive participants. Such conferences did little to develop their skill in communications and it did nothing to stimulate their initiative or judgement in seeking library sources of information. Basic texts and procedure books were on each ward and seldom used. Yet the nurses said they did not know what the trainees were taught in the classroom.

With the cooperation of the supervisors and head nurses, the staff nurses were designated conference leaders on a carefully planned rotation. At first they were encouraged to select topics on ward procedures and routines within their grasp. These they taught to the small group of nurses and assistants on their ward. The educational and supervisory staff gave detailed help covering every aspect of a conference-finding, the time, setting up the room, arranging light-

ing and ventilation, collecting teaching equipment, and providing ward coverage, in addition to organizing the topic and learning how to stimulate participation of the audience by key questions. Mimeographed directives were available as a check list for conducting the conference. Praise and encouragement were given for their first efforts, and criticism kept to a minimum. Many a nurse wore an unaccustomed flush of pleasure when her ordeal became an achievement. Incidentally, the teacher became the authority on the ward routine she had taught.

After six months, the conferences graduated to topics on communication skills, job satisfaction, interpersonal relationships, etc. The staff of two or more wards combined to attend these carefully scheduled discussions. Later, case studies of patients were introduced following by "continuity of care, hospital to home, and rehabilitation." These topics naturally led to an inclusion of the dietitian, corrective therapist, social worker and others in a panel discussion. With broader handling of topics, more formal type conferences evolved, of interest to a larger audience, so the staff nurse leader moved into the general conference room for her "little talk."

Those nurses showing most competence were then selected to give an hour's program to a large group of nursing assistants. The topics were geared to the men's needs and comprehension. By emphasis on key questions which stimulated discussion by the men, the nurse acquired a new respect for their ability to observe carefully and interpret accurately. Part of each of these 16 classes was devoted to explanation of anatomy and medical terminology, which made the nurse conscious of the complexity of hospital jargon as it falls on the unaccustomed ear.

The first year of ward conferences readied the staff for the Team Plan which was started in 1954. Favorite topics for that were "Leadership Skills, Patient Assignments, Team Conference, and Nursing Care Plans." The Team Plan was a tremendous boost to proper guidance of nursing assistants. As Team Leader, the staff nurse fully accepted her responsibility for nursing assistants in a structured situation.

One other phase of our program offered direct help to nurses in their teaching duties. Those nurses who said they did not know how or what the trainees were taught in the classroom, were shown. Only a sampling of one nurse from each ward attended a few classes with a discussion period afterward. They saw for themselves that the familiar principles and practices had not changed, and this they reported back to the ward staff. They were assured that good old "Harmer and Henderson" was the nursing bible of most nursing schools. Extra hospital procedure books were made available for home study. But more important, we relinquished our picayunish attitude regarding the exact specifications of detail in procedures.

Summary

The emergency situation in 1953 had focused our energies on improving the staff nurses' ability to teach and supervise nursing assistants in the ward situation. The skills they developed for this responsibility prepared them for the Team Plan, which quite fully achieved our objective. From the inception of the program, nursing assistants received increasingly improved guidance which prompted safe, thorough patient care even though our staffing pattern continued the trend of fewer nurses and more nursing assistants.

The Care of Long Term Illness Patients on Intermediate Bed Services

By
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THE Commission on Chronic Illness has defined chronic illness as "Any illness of three or more months duration. The problems of chronic illness and those of the aging are often confused due in part to the fact that many of the problems of older people become complicated by some form of chronic illness. Not all of the chronically ill are aged nor all of the aged chronically ill, but the percentage of incidence of chronic illness is higher among the older members of the population than it is in any other age group."[1]

The Veterans Administration has long recognized and been concerned with the increasing problem of caring for the aging and chronically ill veterans. Sporadic individual programs have been developed since 1950. Intermediate bed services have been established separately in individual hospitals to care for long term illness patients.

A recent exploratory survey by the Veterans Administration revealed the fact that 6,253 long term patients meet all of the criteria for admission to an intermediate bed service in general medical and surgical hospitals and that 3,446 domiciliary members would be eligible for admission to such a service. It is anticipated that the problem of chronicity or long term illness will increase concurrently with the constantly increasing age of the veteran population as a whole, as well as the inevitability of greater disability in the aging domiciliary member group. In the past, health programs were directed toward prolonging life but today we must concentrate on making the entire lifetime one that is healthful and useful. This, in spite of the quotation attributed to Dr. William Osler who said "The best way to live to a ripe old age is to early in life get a chronic illness and then take care of yourself."

The majority of patients (1,621) with long term illness first transferred to general medical and surgical hospitals intermediate bed services were carefully selected, so called "burned out" patients, from predominantly psychiatric hospitals. Many of these patients had been hospitalized from five to twenty years. This led to some confusion and apprehension on the part of medical and nursing personnel. Physical facilities for safeguarding these patients were not always available and the staff was not prepared for this clinical field of medicine and nursing. Many patients required far more personal care than had been anticipated. In fact, the need for nursing care was equal to or greater than that required on an acute ward.

Many patients were aged and infirm, physically handicapped by crippling diseases such as arthritis; others had disabling contractures; many were soilers and other behaviour deviates who required understanding, unlimited time, knowledge or rehabilitative measures and use of the most basic effective skills in nursing. Application of all these skills is essential, if the patients are to be kept at the maximum level of effective living.

Observation of the care of these patients in eight Veterans Administration Hospitals revealed evidence of excellent physical nursing care. Patients were clean and appeared comfortable, but an important element was lacking. Dr. Lucy Ozarin aptly expressed this element when she said "As long as individuals are called patients, regardless of their type and stage of illness, and as long as physicians are responsible for their care,

there must be active treatment going on. The patients cannot be allowed to sit in apathy."

It is obvious that the ability of these patients to gain the best results from medical care will depend upon how successful their social needs are met. In order to treat the patient—a person—the nurse must have a complete knowledge of the patient's physical and socio-economic background. She must understand the patient's fear or acceptance of dependency. She must be able to recognize his need to be socially useful and the need for planned creative recreational activity.

Our Veterans Administration hospitals, like other modern hospitals are designed, equipped and staffed for the care of acutely ill patients. Let us face the fact that the construction and administration of the average general hospital is not always the most satisfactory place for the care of the patient with chronic illness. Florence Nightingale wrote "Hospitals are at best only a necessary evil . . . a necessity in an intermediate stage of civilization. . . ." And, Dr. Sydney Shindell has stated that "70% of those afflicted with long term illness can best be cared for at home, provided adequate supervision and assistance are available." While we may not be in complete agreement with this thesis, we would agree that we should not fall into the danger of mentally accepting *any* individual as a long term illness patient doomed to a lifetime of hospital or institutional care. Treatment should be continuously directed toward halting deterioration, restoring forgotten abilities and/or teaching new ones, so that each individual may enjoy the highest possible level of health and social effectiveness.

Consideration should be given to the physical environment desirable for these patients. If possible, they should be near or on the ground floor. Ramps for wheel chair, or cane and crutch using patients would provide an opportunity for enjoyment of the outdoors without assistance from nursing personnel. Window sills should be low enough to permit view for wheel chair and bed patients. Patient areas should be livable and as homelike as possible. Furniture should be attractive, comfortable and safe. Color and decoration are important. Built in lockers are essential since patients should be encouraged to wear their own dress clothing for the psychological as well as self-help value. The patients should be protected by the use of physical safety devices, without detracting from the home like appearance. It is needless to emphasize the fact that the ward climate should be permissive. There should be as little regimentation as possible and as is consistent with the medical treatment program.

There is general agreement that a complete medical, including social and vocational evaluation should be made of each patient before he is admitted to an intermediate bed service. Only under rare circumstances should a long term illness patient be transferred out of his home town community, if this means the loss of visits from his family and friends. The ability of the patient to gain the best results from his medical care depends largely on how successfully his social and emotional needs are met. In order to know the patient as an individual, the nurse must have a complete picture of the patient's cultural, social and emotional background. Too frequently we appear unaware that prolonged illness which takes the patient from his role of breadwinner and head of the household creates serious psychological problems for the patient and his family. The need for warmth and reassurance of family and friends is common to all of us and never more necessary than during illness or adversity.

We must accept the fact that there will be a number of individuals who for various reasons will be retained in the hospital for indefinitely prolonged periods. But, do we agree that every community and family resource *first* be thoroughly investigated with the patient's knowledge and help so that he understands that home care is preferable when possible and so that he does not succumb to the dread disease "hospitalitis"?

If *planning* for patient care, including discharge, were to begin at admission to the

hospital, is it not possible that attitudes of hospital personnel, patients and families might be more favorably inclined to accept hospitalization as the first step only, in a curative, preventive and rehabilitative treatment? There is evidence of need for the hospital personnel to work together, with the patient and his family, so that each member of the "together" group will understand the goal of the medical care program. Only in this way can each make his major contribution to the welfare of the patient.

We as nurses need to possess not only essential nursing skills, but we should also have knowledge of and practice in the use of psychiatric, public health and rehabilitative nursing principles and methods. We could be more effective if we were equipped with this preparation and experience and with a background of practice in teaching and supervision. In addition, we must have an understanding of each patient, of his cultural, emotional and social background and how these affect him as a person when meeting the crisis of illness. Nurses must be better equipped to meet the patient's need for resocialization and to assist with special therapies such as occupational, corrective therapy, and others which to effect the best results must continue throughout the day. No hospitalized patient should be allowed to markedly regress mentally, socially and physically, where all the therapeutic modalities and medical personnel are available.

It has been said that the nurse must learn how to promote self-help and foster independence in these patients. She must learn how to assist the patient in doing things for himself instead of doing things to and for the patient. This practice is desirable for all patients, in order to prevent many of the physical disabilities and the mental regression which has been observed in too many long term illness patients. The nurse must learn to control her impulse to help, by taking over the activities of daily living. For example, the patient should be encouraged to brush his teeth, tie his shoe laces, dress and feed himself. The nurse must become a teacher instead of a "do-er." She must teach the patient, the nursing personnel, volunteer workers and family. They must understand the reasons for this practice of self-help, if the plan is to be successful.

Since the Veterans Administration is committed to the care of thousands of long term illness patients, it seems appropriate that we consider briefly the vast unexplored area for the increased use of volunteer workers in this service. Many additional American Red Cross Volunteer Nurses Aides could be used to advantage in giving personal care to the patients, who cannot be hurried, if they are to re-learn self care and independence of action. The ability of the patients to reap full benefits from medical care will depend on how adequately their social needs are met. Too many patients have been separated from their family and friends for too many years. They need warmth and reassurance of family, friends, medical and nursing personnel and of the community represented by the volunteers. They need to be encouraged to go out into the community and to participate in community life, including normal spiritual and social activities.

Do we, as nurses, take for granted that we are understood when we talk about rehabilitation of these patients? Does our goal seem unrealistic? The National Council on Rehabilitation, in August 1943, adopted this definition: "Rehabilitation is the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable." The last clause emphasizes possibilities for the rehabilitation of every patient. The preparation of the patient for activities of daily living requires new knowledge and skills for the nurse. She must know not only what the patient wants, but she must also be able to kindle the spark which will make him want to move forward. The nurse needs guidance from the physician who is well informed on the values of rehabilitation. She needs to understand her own attitude in regard to old age and chronic illness. Howard Rusk says "The attitude of the physically handicapped individual toward his own disability

is a reflection of the attitude of those with whom he comes in contact." A hopeful and helpful attitude is essential. The nurse needs ability to share her knowledge with co-workers, the patient and his family. She needs to know how to obtain help when indicated from the social worker, dietitian, physical medicine and rehabilitation therapists, spiritual counselor, volunteer service and the community public health nurses. Whenever and wherever possible the nurse should have experience and preparation in rehabilitation through resources such as the Institute of Physical Medicine and Rehabilitation of the New York University-Bellevue Medical Center and/or through other university planned courses.

Do we accept rehabilitation as a goal—not as a miracle? Do we recognize it in the performance of daily and repetitious duties? Does the patient see it in his constant effort to do more and more for himself and for others? Is this goal shared by all who are associated with the patient's care, including the patient and his family? Do we see the challenge for nurses as envisioned by a distinguished nurse, the late Ruth Weaver Hubbard, who defined rehabilitative nursing as "helping every patient to do *as much* as he can *as well* as he can for *as long* as he can"?

For those who have imagination and believe in the "worthwhileness" of the individual, nursing care of long term illness patients can be a never ending source of satisfaction.

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ACCIDENT PREVENTION

There is a reason for every accident.
Find the reason; correct the fault;
prevent a future similar accident.

Isotope Therapy and Nursing Care Precautions

By

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NURSING care for patients receiving therapy doses of radioisotopes will present a problem in each individual case, due to the hazard of exposure of nursing personnel to radiation. No problem exists in a patient treated *externally* with X-rays, radium or any radioactive substance *after* the treatment has been completed. It is only when the radioactive material is actually present in or on a patient's body that there can be any problem in nursing care because of radiation hazards.

Isotopes are atoms that belong to the same element, such as iron or calcium, but which have slightly different weights because of the varying numbers of neutrons in their nuclei. Isotopes of some elements are radioactive in that they send out rays that cannot be felt like heat, seen like light, or heard like sound. These rays, however, can penetrate solid matter and can be detected by special instruments.

Radium is a metallic, radioactive element which is constantly emitting energy. Radium has been in use for over fifty years. Its chief property is in the emitting of three types of ionizing radiation that destroys living tissue. The gamma rays represent the energy that concerns us, as it is this particular ray that has 100 times more penetration than beta rays, and is used extensively in the irradiation of cancer. Irradiation results in a transfer of energy from the radioactive material to the affected cells.

Isotopes of some elements, such as radium and uranium, are naturally radioactive. The elements not normally radioactive can be made so, artificially, in atomic piles or reactors. This is done by placing the elements in the atomic pile or reactor and bombarding them with neutrons. The nuclei absorb enough extra neutrons to make them unstable and therefore radioactive. They then begin to give off rays which can be detected by the special devices used for this purpose, such as the Geiger counter or ionization chamber. The intensity of rays given off by the various kinds of isotopes varies according to the rate at which they lose their radioactivity or the half-life. The half-life of any isotope is the time required for one-half the atoms of a radioactive material to disintegrate. The half-life of radioactive iodine is 8.14 days or the period of time in which it will lose one-half of its radioactivity. The half-life of radioactive gold is 2.69; the half-life of radioactive phosphorus is 14.3 days and that of radioactive chromium is 27.8 days. Radium has a half-life of 1599 years which means that it will lose half of its energy in the first 1599 years, or the first half-life.

It is important at this point to discuss radiation and exposure. We are living in a field of natural radiation from cosmic rays and radioactive materials in the earth. This radiation level is approximately 0.3 mr/week and is considered to be normal. A permissible level for occupational exposure to radiation has been established by authorities on Radiological Protection at 300 mr/week. The "r" or roentgen is the accepted unit of X or gamma radiation and is a very small fraction of the amount that is necessary to produce any visible effect on the skin. The permissible weekly dose or exposure to radiation is of the same order of magnitude as that received in the course of certain types of X-ray exposure. The "mr" or milliroentgen is a submultiple of the roentgen or 1/1000th of a roentgen. Personnel who, by virtue of their occupation, are exposed to radiation, should always wear film badges and when indicated, the small pocket type of ionization chamber in order to check on the amount of exposure received.

A therapy dose of a radioisotope is always very carefully calculated as regards

the time element, the location and amount of the isotope, the half-life and the effect desired, and the size of the patient. Radium, which is a solid, is administered in milligram amounts. (One milligram is a one-thousandth part of a gram.) Therapy doses of other radioisotopes are given in millicuries and the tracer doses are given in microcuries. A millicurie is defined as that amount of radioactive material which decays at the rate of 37 million disintegrations per second. This is approximately the activity of a milligram of radium. A microcurie is a submultiple of a millicurie, or a one-thousandth part of a millicurie.

Precautionary measures in giving nursing care to patients receiving radioactive isotope therapy includes: (1) the time necessary to give adequate nursing care; (2) the distance between the nurse and the patient; and (3) barriers, which give added protection and are found in walls of brick, stone or lead. The best protective barrier at a nursing level will be found in the additional distance that can be placed between the nurse and the patient. Full advantage should be taken of the law of the inverse square in order to minimize exposure to radiation. (Inverse square law: Intensity of radiation varies inversely as the square of the distance from the source.) Example: A nurse four feet away from the source of radiation will receive only one-sixteenth as much radiation as would a nurse standing one foot away. Another protective measure will be found in the wearing of rubber gloves when giving nursing care to patients who have received therapy doses of radioactive gold or iodine, as exposure to the beta radiation is reduced seventy-five per cent in this manner. It is important to remember that any radioactive substance is never handled with the hands or fingers, but is manipulated with long forceps or the specific devices made especially for such purposes.

Since radium emits energy constantly, and all factors being considered regarding the length of the treatment, the location, the amount, the effect desired, the size of the patient, and the various barriers, the time element for giving nursing care must be considered in each individual case. Example: For a patient being treated with an intracavitary applicator containing 86.4 milligrams of radium, the total time to be spent in giving nursing care to this patient would be 100 minutes, or one hour and forty minutes for the length of the treatment, at a distance no less than 25 inches between the nurse and her patient. As mentioned previously, the time element will vary with every patient and with every treatment with radium.

The patient receiving radium therapy is always a radiation hazard for as long as the radium remains in or on the body, and this type of patient is always isolated for the period of the radium treatment. (The ideal arrangement for giving nursing care to patients receiving any type of radiant therapy would be to isolate them all in one section of the hospital, but this would be rather impractical in an Army installation for several reasons.) Isolation is best achieved in a private room, but can also be accomplished in an open ward, with the patient in a cubicle, with empty cubicles to either side and to the head and foot of his bed.

After the radium has been placed on or in the patient, the time for removal at the end of the treatment period will be indicated on the patient's chart by the doctor. The responsibility of checking for dislodged needles, applicators, molds, etc., will be that of the nurse, as a general rule. When a shift in the position of radium needles, applicator, mold, etc., is apparent, the doctor must be notified at once. Radium by this method is not excreted from the body in any manner, so the linens, equipment, dishes and furniture are not considered contaminated in any way.

In every hospital where isotopes are used, there is a Radiation Safety Officer whose responsibility it is to safeguard the personnel from exposure to radiation over the permissible dose of 300 mr/week, and to protect other patients from becoming exposed to radiation from those receiving radioactive therapy. It is also his respon-

sibility to determine when it is safe for an undertaker to remove the remains of a patient who has expired after radioactive isotope therapy. He is also responsible for the periodic blood counts on all personnel working with radioactive materials and takes steps to relieve situations when such personnel reflect over-exposure. It is his responsibility to determine when contaminated equipment and linens have passed the decay period prescribed and are no longer radioactive. It is his function to advise and recommend on all topics relating to radioactivity and full advantage should be taken of his capabilities whenever necessary.

The most common isotopes in use today are Gold (Au-198), Iodine (I-131), Phosphorus (P-32), and Chromium (Cr-51). Radioactive gold is used to treat carcinoma of the prostate gland in certain cases, and is injected into the gland during surgery, using a lead-guarded syringe made especially for this purpose. The gold is also used in certain conditions in the thoracic cavity and abdominal cavity and is instilled immediately after thoracentesis or paracentesis in millicurie amounts, using a lead-guarded syringe. Sterile technique is carried out when the instillation takes place, not only because of the danger of introducing infection, but because of the possibility of spillage and thus contaminating the operating room or the patient's room with the radioactive material.

Radioactive iodine is used in the diagnosis and treatment of thyroid diseases. It is given in millicurie amounts for therapy and in microcurie amounts for tracer doses and is always diluted in water and given by mouth. Radioactive phosphorus is used in treating polycythemia vera and is given intravenously in amounts varying between three to eight millicuries. It is also given intravenously in amounts varying between 100 to 600 microcuries for localizing and determining malignancy in eye tumors. Radioactive chromium is given intravenously in amounts of 25 to 50 microcuries and is used to determine the red blood cell survival rate.

The patient receiving radioactive gold therapy is a distinct radiation hazard for four days, and is always isolated for that definite period of time. Three days following the instillation of radioactive gold, the patient is usually "scanned" with one of the monitoring devices to determine the amount and location of radioactivity. The distribution of activity does not change appreciably with time, but the intensity decreases considerably, approximately twenty-five per cent in every 24 hours, due to radioactive decay, in its short half-life of 2.69 days. The safe time for nursing care with this type of patient is approximately five hours total for the entire time that the patient is considered a radiation hazard, and the safe distance of no less than twenty-five inches kept between the nurse and patient. After the fourth day following the instillation of the radioactive gold, sufficient dissipation of the isotope has taken place so that the patient is considered no longer a radiation hazard and can be allowed full ward privileges.

Radioactive gold is not excreted in any way and remains in the tumor mass or in the area where instilled until its half-lives dissipate it entirely. The patient who has had radioactive gold instilled into the prostate gland, though, may possibly have some seepage into the bladder, and thus the urine becomes a radiation hazard. In this instance, it is necessary to save the urine for the time indicated by the Radiation Safety Officer, and it is sent daily in 24-hour amounts to the Isotope Department for monitoring and decaying purposes. The catheter, when removed, is also sent to the Isotope Department for the same purposes.

Radioactive gold emits gamma rays plus beta rays, and the use of rubber gloves will reduce the beta ray intensely by about seventy-five per cent. It is recommended that the nursing personnel wear rubber gloves for protection against beta rays when bathing the patient, changing bed linen, giving bed pans, urinals, etc. The rubber gloves must be washed thoroughly after use, while still on the hands, in soap and running water; then removed so that the hands are

not contaminated, and dropped in a paper sack in the patient's room for safe-keeping until monitored by the Isotope Department personnel later.

Radioactive iodine in a therapy dose causes the patient to be a radiation hazard and he is isolated for 24 hours. Within an hour after the patient has received the therapy dose, the isotope is circulating freely throughout the patient's body. The radioactive iodine is excreted in the urine and the majority of it will be excreted in this manner in the first 24 hours. The urine is therefore a radiation hazard also. Radioactivity will be found also in the saliva and blood. Urine must be saved and sent to the Isotope Department in 24-hour amounts for monitoring and decaying purposes. With this type of patient, it is recommended that rubber gloves be worn while bathing him, changing bed linen and attending to his needs. The care of the rubber gloves is the same as described previously. Should incontinence or severe diaphoresis take place, it is necessary to save the bed linens for monitoring by the Isotope Department personnel in order to detect any radioactivity that possibly may be present.

The day after the administration of radioactive iodine in a therapy dose, the general distribution of radiation is greatly reduced, both by urinary excretion and by the concentration of the remaining part in the functioning thyroid tissue, as demonstrated when "scanned." Radioactive iodine, with its half-life of 8.14 days, is reduced in radioactivity by natural decay by about nine per cent per day. The time considered to be safe for giving nursing care to this type of patient is approximately 10 hours total for the 24 hours after his therapy dose when he is considered to be a radiation hazard, at a distance of not less than twenty-five inches between nurse and patient. Radioactive iodine in tracer doses will not cause patients to become radiation hazards.

Therapy with radioactive phosphorus or radioactive chromium can be given to patients in the hospital or on an out-patient basis, due to the low radioactivity of these isotopes. The patients receiving these isotopes will not become radiation hazards.

Conclusion

Safety in nursing care of patients being treated with radium, radioactive gold or radioactive iodine in therapy doses depends to a great extent upon the time factor, distance, barriers and the ability of the nursing personnel to follow instructions. The time factor for giving nursing care to patients being treated with radium is flexible and depends upon the length of the treatment, the location, the amount, the effect desired, the size of the patient and the various barriers utilized, which will differ in every case. However, isolation is required and may be accomplished in a private room or in an open ward, with an unoccupied bed to either side and to the head and foot. The patient is a definite radiation hazard for the entire period that the radium is present in or on the body.

The time factor for giving nursing care to patients being treated with radioactive gold is calculated to be approximately five hours for the period of four days that the patient is considered to be a radiation hazard. This time factor is dependent upon the amount of millicuries of gold used, the location of it and the size of the patient. The safe distance is considered to be no less than twenty-five inches between the nurse and the patient. Isolation is always necessary and may be achieved as described previously.

The time factor for giving nursing care to patients treated with radioactive iodine in therapy doses is calculated at approximately 10 hours for the 24 hours after therapy when the patient is considered a radiation hazard, at the safe distance of no less than twenty-five inches between the nurse and the patient. After this time, the patient is considered no longer a radiation hazard, as he has excreted at least one-half to two-thirds of the total amount of his therapy dose of radioactive iodine in his

urine. Isolation is necessary for the first 24 hours after therapy, and the urine is considered a radiation hazard for two days.

The Radiation Safety Officer has a definite function in hospitals where isotopes are used, and will be found to be of great assistance when advice is needed in every situation regarding radioactivity.

The permissible exposure of 300 mr/week represents a dose which, according to the authorities, has never produced human damage, nor has it ever produced sterility and there has been no evidence of genetic changes. Respect for radioactivity, rather than fear of it, and strict adherence to the rules regarding the time period, distance and barriers for giving nursing care, would seem to be the keynote in giving good nursing care to patients receiving such therapy.

Patient Education in the Management of Pulmonary Tuberculosis

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PATIENT education in tuberculosis is an integral part of the total plan of treatment; for it is by educating the patient that we gain the cooperation which is so important in the success of the treatment program. If we are able to help each patient in understanding and accepting tuberculosis in general and how it affects him, then we can be assured of obtaining the best possible result in his cure and rehabilitation. This is the aim of the Patient Education Program at Fitzsimons Army Hospital, and its success is the responsibility of every staff member who contacts the patient during his hospitalization.

In planning a program of patient education there are certain factors that must be considered:

1. Education must begin at the time the diagnosis of tuberculosis is made, and should be shared by all members of the patient care team.

2. It must be within the limits of the patient's mental and physical capabilities.

3. It must be a continuing process; one that is constantly reinforced from the time of admission until rehabilitation is completed.

4. It must be honest, so that it will concomitantly control and prevent fears, and aid the patient in planning his future.

5. It must instill within the patient the desire to get well and to accept his responsibility as a tuberculosis patient.

6. It must include the patient's family and friends.

7. It must be planned around the rest of the treatment program and be flexible enough to meet each individual patient's needs.

When a patient is admitted to a tuberculosis hospital he is often afraid and confused, and is confronted with many new problems. He has been in a strange environment, separated from his family, and is faced with a long period of hospitalization for a disease which to him is a terrifying one. The initial orientation of the patient to his new experience will lay the groundwork for the development of the all-important cooperative attitude. Individual interviewing and counseling are stressed in the first few days of hospitalization in order that we may become aware of the personal and social needs. This requires the services of the Physician, Nurse, Social Worker, Red Cross personnel, Chaplains and other trained individuals whose services may be necessary. The Social Workers assist with family matters such as helping locate adequate housing facilities, and foster homes when the mother is hospitalized. If financial or transportation problems exist, the Red Cross will provide emergency assistance and aid in long range planning. The Chaplains are available should a spiritual problem be present. The public health nurse helps in arranging for the medical follow-up of family members and other contacts. The physician discusses frankly with the patient his specific disease problem and treatment plan, and why hospital care is necessary in his case. The ward nurses and personnel explain the hospital routines and facilities, such as rest periods, and Gray Ladies service. By helping the patient in feeling secure in knowing we are concerned about him and his problems, we have started the educational program; by helping him solve those problems, we have created an attitude conducive to learning.

However, in these first contacts with the patient, there is one pitfall which must be watched for and guarded against; this is the development of a feeling of shame and despair, almost a parish complex which occurs

all too often in the new patient. A person who is taken from normal society into a world of masks, isolation and ward zoning can be made to feel that he is not only a social outcast but a menace as well. We need to approach this subject of communicability with understanding and a positive attitude; assuming that the patient is interested in learning his part in preventing tuberculosis. A brief "matter of fact" explanation of transmission of the germ followed by the methods we have devised to help him prevent the spread of germs, will suffice at the time of admission. We have told the patient why we must maintain a particular ward set-up, and have shown that we trust his good judgement in helping us to do so. Hence, we have accomplished two objectives —at least in part—we have enabled the patient to keep a sense of dignity and have stressed the necessity of cooperation. Since we have mentioned cooperation, there is one other point which should be made, and that is that we stress from the first moment of diagnosis the large part the patient is going to play in his recovery. He must realize that this is not an illness we can cure FOR him, but one we can cure WITH him; that he too is a member of the health team.

While the patient is on the admission ward he is asked to take part in the group discussions and talks which are held at frequent intervals. In these discussions the general aspects of tuberculosis are explained in lay terms. The tenor is as informal as possible; however they must be guided to prevent monopolization of the discussion by the loquacious members. Also, there is a certain amount of material that must be covered, so a plan of some sort has to be followed. Physical set-up is important too; there should be room available, away from the distractions of the ward, which can be used for the educational program. If at all possible, the room should be large enough to permit showing of films. If the condition of the patient does not warrant participation in the group, he is given individual instruction at the bedside.

In brief, these are the topics that are covered during the early stages of hospitalization:

I. Explanation of the disease in general:
   a. Causative agent.
   b. Methods of contraction and transmission.
   c. Social aspects; patients role in preventing spread.
   d. Symptoms, with emphasis on the asymptomatic tuberculosis.
   e. Diagnostic tests and examinations and their purpose.
   f. Extent and classification of disease.

II. Prophylactic methods:
   a. Demonstration of mask technique, explanation of why and when they are used.
   b. Demonstration of use of tissues and their disposal.
   c. Explanation of Ward Zoning.
   d. Explanation of Visitors Rules.
   e. Discussion of good hygienic habits.

III. Treatment of Tuberculosis:
   a. Rest
   b. Drugs
   c. Surgery
   d. Supportive treatment, such as nutrition, etc.

IV. Psychological Aspects:
   a. Acceptance of diagnosis and treatment.
   b. Emotional aspects of hospitalization.
   c. Importance of mental activity:
      Occupational therapy
      USAFI courses
      Library facilities, etc.

Audio-Visual aids are a great help in reinforcing the teaching program. The following are used very effectively:

1. Booklets

These may be obtained from the Veterans Administration (VA), National Tuberculosis Association (NTA); and also can be prepared by the staff at the individual hospital. They are given to each patient, and he is asked to keep them throughout his hospitalization so that he will be able to refer to them from time to time.

2. Films

These are also obtainable from the Veterans Administration and National Tuberculosis Association. Films are always very well received by all patients, and can be shown right in the ward if necessary.

3. Isotype Posters

These are of great help in explaining the spread of tuberculosis, and show very graphically how the patient can help in tuberculosis control.

4. X-Rays

Normal films are compared with those showing abnormalities.

5. Cultures

Negative and positive culture tubes are used as

an adjunct in the discussion of tests and examinations.

6. Models and Charts of the lungs

These are used during the explanations of tests and examinations, and also when surgery is discussed.

7. Books

Many books written by former tuberculosis patients are available in the library as well as others dealing with all aspects of tuberculosis. These are listed and described, and the patients are encouraged to read them.

It is impossible, during group discussions to go into each individual problem; and it is explained to the patients that their physician will discuss their case in detail with them. Individuality of treatment is stressed as much as possible; that the patient will be placed on the treatment regimen which will be most beneficial for him. The same answer is given to the inevitable question about length of hospitalization.

There are two psychological dangers which are always with us and about which the new patient needs warning. These are: (1) The "Old-timer" who has been in and out of tuberculosis hospitals for years. He is always very willing to let the newcomers know how much more he knows than the physician, and he doesn't hesitate to diagnose, prognose, and treat; provided he has someone to listen; (2) Rumors—these unfortunately are very difficult to control because they have usually spread throughout the entire ward before they reach the ears of the staff. Rumors can be very disconcerting to the new patient, especially if they concern administrative and financial matters as they frequently do in an Army hospital.

Once the patient has left the admission ward there is, all too often, a tendency to forget one of the most important underlying principals of patient education—that it is a continuous process. Yet this is the time when it is most needed—during the long period of treatment. This is the time when we must continually reinforce and re-explain, for as the patient progresses, the facts about tuberculosis become more meaningful to him. Also this is when the tendency to leave the hospital against advice is most prevalent. Unless we help the patient keep himself mentally occupied, he will become restless and time will hang heavy, and as boredom increases so does the desire to leave the hospital. If family problems should arise, assistance from the social workers will be needed to prevent the patient from going out and settling things for himself.

We can see the need here for education of the family. Unless the wives and husbands understand thoroughly why such a long period of hospitalization and inactivity is necessary, they might be the cause of the patient discontinuing his treatment. It can be very difficult for a husband to carry on the household duties as well as a full time job should the wife be hospitalized; and the same is true for a wife whose husband has tuberculosis. The situation may seem a bit unfair to these people, especially when the one who is ill looks healthy, feels well, and has nothing to do but rest all day and "enjoy life." If at all possible, it is an excellent idea for the public health nurse to interview the family members to explain the principles and treatment of tuberculosis; too, the better we know the family, the more we are able to understand the patient. The physician can explain the specific disease problem, so that the family will be able to do some long range planning.

Booklets should be made available to all visitors; and visitors discussion groups, similar to those held for the patients, have proven very successful. We must help these people to recognize the part they are playing in the recovery of their loved one. It isn't enough to say "Be cheerful when you visit"; rather we must explain how some seemingly harmless bit of bad news can gain inordinate proportions to one who is not in the situation and can do nothing but brood about it. Families should be made familiar with the personnel agencies available if outside help is needed. This does not mean that the hospitalized member of the family should be left out of all affairs. Every effort must be made to help him retain his place in the family group. Rather, we mean the issues about which the patient can do nothing, and which may lead to feelings of inadequacy and letting the family down, should be excluded from the visition hour conversation.

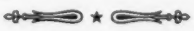
Questions regarding the disciplining of children, for example, can be discussed just as they would be in any normal home situation.

It is important to the patient that his care be reviewed frequently with him—that his progress from the time of admission be demonstrated to him periodically. As long as he can see progress, regardless of how slight and slow it may be, his morale can be kept up; we must help him to recognize each small step in the right direction as a step closer to a normal life.

When the arrested stage is reached, and plans for home care or convalescent leave are being made, the patient is faced with another period of adjustment. Just as he needed preparation and help when he entered the hospital, so he will need it before he leaves. The "dependency complex" which tended to develop in tuberculosis patients previously, is usually no problem in these days of shorter hospitalization and increased activity. However the hospital environment is certainly a sheltered one and it can be very difficult to leave it and be on one's own again. Preparation for this change can be accomplished through personal talks and discussion in groups. It must be stressed that he is still a patient, but in a home setting, and as such will have to follow a routine concerning drugs, rest periods, clinic visits, etc. He will probably need help in planning his home care, but this should be a passive and directive type of assistance, so that the patient and the family will assume the responsibility which is rightfully theirs.

Above all, consideration will have to be given to the rebuffs and insults that might be forthcoming from people who are uninformed or ill-informed about tuberculosis and its treatment and prognosis. Unless the patient is warned about this, it can be a very traumatic experience for him. But, if we are discharging a well adjusted, well informed person, he will be able to cope with the situation, and recognize that attitudes of that sort are based only on ignorance; and by passing on what he has learned he will be doing his part in dispelling that ignorance.

In conclusion, I would like to repeat that Patient Education is the responsibility of all of us who have a part in the care of the patient; that every contact we have with him is a learning experience. Whether it is a fruitful one or not depends upon us.



Packages for overseas must be mailed by November 15 to insure delivery by Christmas.

The Role of the Army Health Nurse in the Preventive Medicine Program*

By
LIEUTENANT COLONEL JOSEPH W. COOCH, MC, *U. S. Army*†

THE Army Health Nursing Program as set down in AR 40-551 is, of necessity, an integral part of the Preventive Medicine Program It is difficult to imagine a comprehensive preventive medicine program without the performance of the responsibilities described in that regulation. It is, likewise, difficult to imagine an Army Health Nurse operating in a vacuum where no other preventive medicine program exists. It is, therefore, of great importance that the relationships between these interdependent programs be firmly established within a broad range of flexibility.

It must be recognized that the situation, as exemplified by geography, the weather, proximity of other health agencies, organization of other medical services, numbers of soldiers and dependents to be served and other variables, will modify the program considerably. No rigid lines can be laid down, therefore, to fit all situations to the same pattern.

We must further recognize that we are pioneering in a new field of Army Preventive Medicine and that firm limitations on our activities can only impair our usefulness and reduce our opportunity to meet new challenges as they arise. The program, as I shall discuss it here will be, then, an example of one which can be developed, rather than what is best for some other situations or what I may consider to be the ideal.

I hold no brief for those who debate at great length which of the various administrative chains of command is necessarily the best. It is less important that the Army Health Nurse be responsible to the Preventive Medicine Officer or to the Chief Nurse than that all involved recognize the roles each should play. The situation will determine which organizational structure is best. In this matter, as in many others, the personalities of the individuals assigned to an organization often make necessary a modification in organization structure, in order to secure the maximum performance of those individuals who work well together and to avoid friction between those people whose personalities clash.

The scope and limitations of the program at any post may be delineated in broad terms but all concerned should keep uppermost in their minds the need for flexibility, the importance of a mind receptive to new ideas, and a willingness to adopt new programs and technics as they are needed or discard old ones which are no longer necessary nor profitable.

What then are the fields where the Army Health Nurse can contribute most to the Preventive Medicine Program? As I see it, they encompass all phases of public health nursing but should be concentrated in the fields of maternal and child health, communicable disease and health education. These are broad areas and I shall discuss them separately, being fully aware that there is considerable overlapping.

In maternal health, the prime point of usefulness of the Army Health Nurse is in education. Whether this education should be given in the prenatal period or be directed at new mothers is a matter of considerable debate. The need for education of prospective mothers—and fathers—cannot be denied but need and ease of accomplishment do not always go hand in hand. Only recently have adequate facilities for a prenatal class been available at Fort Dix and such classes have been instituted.

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* Presented at the First Institute of Army Health Nursing at the Walter Reed Army Institute of Research, Walter Reed Army Medical Center, Washington, D.C., on 5 March 1956.

† Chief, Fort Dix Health Center, Fort Dix, New Jersey.

Most efforts in this field have been devoted to an intensive program of postnatal classes. Up to one hundred and fifty deliveries a month are performed at Fort Dix and most of the patients are discharged in from forty-eight to seventy-two hours after delivery. Roughly four out of each five patients attend a class, while they are still in the hospital. These classes are held in the obstetrical wards and are devoted to the care and feeding of the baby and to the care and behavior of the mother. Questions are encouraged and individual problems are discussed. The interest at these classes is high and the groups are small enough to be efficiently instructed.

The home visits to new mothers are limited almost entirely to persons living within eight miles of the post. Arrangements are made with civilian public or voluntary health agencies for visits to others. Priority for visits is given to mothers of premature babies, to primiparas and to patients who have special problems, which have come to the attention of the staff of the Obstetrical Service or the Army Health Nurse. These visits are primarily concerned with infant care but also involve education of the mother concerning her own care. Other problems in the home are sought for at each visit, so that no home visit ignores any health problem which the nurse encounters.

The child health program begins when the new mother attends her postpartum class and continues during the first home visit. An attempt is made, at either or both occasions, to give the mother an appointment to the Well-Baby Clinic. Here, the Army Health Nurse assists by weighing and measuring, interpreting the mothers' needs to the physician, interpreting the doctor's instructions to the patients, arranging for specialty follow-ups, and conducting a continuing educational program by means of posters, pamphlets and oral instructions. Children are followed monthly for six months and longer if indicated. They are seen also at a year, although attendance after six months falls off considerably.

The Army Health Nurse maintains contacts with the growing child from this point onward mostly as problems arise. Those who have a continuing medical problem are followed by home visits. Those with communicable and non-communicable disease receive home visits on request of the pediatrician or dispensary physician who has been consulted by the family. More frequently, however, other problems within the family are the usual reasons for further home visits and the nurse makes sure that each visit includes a review of the progress of the child and an attempt to bring out any problems which may have been encountered.

At age five the child health program and the school health program become a common one. One difference in the school health program in a military installation from its civilian counterpart is the fact that the Army Medical Service acts in the dual capacity of a public health service and the private practitioner for the children attending the school. Children who are dependents of military personnel attend many schools in the vicinity of Fort Dix, these schools being in the jurisdiction of a good many different and independent school boards. All these children, however, look to Fort Dix for their medical support.

Each school board in New Jersey carries a legal responsibility to provide a school health nursing service which satisfies part of the needs of these children but not all of those felt necessary to fulfill both obligations of the Army Medical Service. It is felt desirable not to duplicate by the Army those services which are completely provided by the civilian agency but to supplement services not entirely covered by the civilian nurse or to introduce new programs not furnished at all.

Another difference is the great turnover of children as compared with the average civilian community. As a result, programs devised to reach children at regular intervals by focusing on certain grades will miss entirely a great many children who come to and leave the school within a year. For this reason, all phases of the program are set up to reach every child every year and the

number of children who are examined more frequently than is necessary is few.

Conduct of the school-age phase of the child health program is almost entirely in the hands of the Army Health Nurse with supervision by the Preventive Medicine Officer.

Twice a year a round-up is held to which all dependent school children are invited who have not been seen before or who have not been seen for one year. These are held in May and November and take place at the Fort Dix Health Center. At these sessions the children receive a urinalysis, chest x-ray, screening hemoglobin test, dental survey and a complete physical examination (less vision and hearing). All defects noted are referred at the time to the appropriate specialty clinic for further work-up and treatment. Immunizations are caught up at the same time. As an idea of the magnitude of this work, in May 1955 we examined 676 children and in November, 1,124. In the latter group 477 referrals were requested of which seventy percent had been completed within three months.

The part of the Army Health Nurse in this program is to share in the planning and arrangements for these examinations, to supervise the many volunteers and duty personnel involved, to take care of arrangements for follow-ups and to keep track of the data obtained. The records are kept in the files of the Army Health Nurse and are available to parents when they leave the area. Pertinent information is given to the school authorities, particularly where special consideration must be given to any child.

Threshold audiometry and the Massachusetts Eye Test are performed by the civilian school nurse on all children attending the Post School and the other schools in the districts where most of our dependent children live. We, therefore, do not repeat these procedures.

Children who are found by the teachers to have any problem which may be medical or psychiatric are referred by them to the civilian school nurse. She in turn refers these, as well as children whose vision or hearing is below normal, to the Army Health Nurse who sets up appropriate conferences with the pediatrician and other specialists as well as with the parents in order to secure any necessary treatment.

The Army Health Nurse also secures and makes available to the civilian school nurse various types of health education materials and assists her in presenting them to the children.

Further follow-ups are made on children upon referral by the pediatrician or dispensary physicians or by medical officers in the hospital who feel that public health nursing services are indicated.

The problems of communicable disease which involve an Army Health Nurse are not too frequent at Fort Dix. Most of these involve tuberculosis or venereal disease.

The activities in tuberculosis cases involve instructive visiting nursing, arranging for follow-up of ambulatory patients in the appropriate clinics, liaison with the public health agencies and social service-type help. She maintains a file of cases under observation and communicates with other military posts when the patient moves with her sponsor.

In venereal disease cases involving females, the Army Health Nurse is informed as soon as the diagnosis is made. She largely interprets the doctors' findings to the patient, discusses contact history, arranges for follow-up and maintains a file of those cases under active observation. She also interviews female military personnel who are named as venereal contacts and arranges for their examination, treatment and follow-up. The occasional positive serologic test in children also calls for follow-up by the nurse.

Other communicable disease problems are less common, but the Army Health Nurse is often asked to make home visits where there are cases of the children's communicable diseases, as well as skin diseases, hepatitis, intestinal parasitosis and so on. At these visits, she is primarily concerned with instructive nursing but spends considerable time in discussion of methods of prevention of new cases. As always, she searches for

other health problems in the home so that each visit is, again, a family health service.

The part that health education plays in these other aspects of the Army Health Nurse's activity is already apparent. Most of her activities in maternal health work are educational. In the field of child health, fully fifty per cent of her work is health education; in communicable disease likewise.

Her health education activities extend beyond these fields. Much of her time is devoted to teaching other professional personnel: doctors and nurses, of the services she can render and how their own fields of usefulness can be extended through her. She participates in the in-service training programs but, beyond them she conducts a continuing campaign among individuals to make use of the Army Health Nursing Service.

She also procures various literature, posters and films for education of parents, of female military personnel, of male military personnel, of all who come within her range. These cover all fields of preventive medicine from safety to geriatrics and from infant feeding to cancer facts. She gives talks to the WAC Detachment on the subject of personal hygiene and, all in all, reaches many people who do not know the extent of her influence.

There are, of course, many other fields where some of her time is spent. She is a source of information to the sanitation section on problems of housing. She sets up and maintains an effective liaison with civilian health agencies, both governmental and voluntary. She makes home visits to instruct in cases of non-communicable disease. The list is endless and to try to recount them all would be pointless.

It should be pointed out that many of the problems any Army Health Nurse encounters go far beyond the field of nursing and, in fact, well beyond the conventional limits of Preventive Medicine. The failure of one of a large family of children to attend school may well be due, as it was in one of our cases recently, to the inability of the parents to pay for proper clothes for the child. Here the nurse is, of necessity, the social worker who helps the family with their budget, who arranges with various people to donate clothes, who urges the Parent-Teachers Association to put the family on their Christmas food-basket list, to get free school lunches for the children and to arouse the interest of other groups who can put the family back on its financial feet. This type of activity is prevention of truancy, juvenile delinquency and possible future heartbreak.

At Fort Dix certain phases of public health nursing are in less demand than elsewhere. We have very few retired personnel to serve, so that geriatrics and chronic disease are not stressed. We find little part for nursing as part of our mental hygiene service, since our mental hygiene program consists primarily of short-term cases among basic trainees. There has been little rheumatic fever to follow-up. We do not feel that these are fields from which the Army Health Nurse should be excluded, but at our post they are problems of lower priority. At some other posts nursing programs directed at these problems would be indicated.

In order that the Health Nursing Program and the Preventive Medicine Program may be more closely allied, it is important that the nurses' reports be designed to give to the Preventive Medicine Service a knowledge of the existence of diseases or situations which may have a public health aspect. The occurrence of disease not otherwise reported should be included as well as the information pertaining to unsanitary conditions, safety hazards, unsound health habits and nutritional habits which are beyond the scope of the Army Health Nurse to correct on the spot.

Such reports should not duplicate those prepared elsewhere and their preparation should consume as little time as possible and still give an accurate picture of the activities of the nurse and inform related services of their own problems of which they may not otherwise be aware.

I have omitted, no doubt, mention of many fields of service in which Army Health Nurses should and do participate. The nurses should, when they can spare the time, pursue

some fields of interest as their minds direct them, for there are many unexplored pathways where an imaginative mind can devise some very useful technic or program. It is incumbent upon Preventive Medicine Officers to encourage this sort of experimental work, but unfortunately, at so many posts, the pressure of day-to-day routine leaves little time for exploring. We should all try to relieve the Army Health Nurse of routine chores of clerical work, clinic duty, administrations of immunizations and outpatient duty by giving such work to less highly trained and more easily available ancillary personnel.

There are far too few Army Health Nurses to have their work dissipated upon a myriad of little projects and it is well that their greatest efforts should be directed at whatever are the major problems of the area in which they serve.

A corollary of the preceding sentence is that the Army Health Nurse should participate in the overall planning of the Preventive Medicine Program. She should be kept informed of changes in the personnel, mission and activities of the post which may make her problems subject to change. Morbidity reports should be available to her as well as any incidents which may affect her activity. We do not always do all of those things, I am sure, but it is our goal and it is only by following such precepts that we can expect to achieve the maximum effectiveness of our Army Health Nurses.

In the final analysis, an Army Health Nurse, well-informed of the situation facing her, respected for what she can contribute and given a free hand to combat the major problems she encounters, can be one of our most effective members of the Preventive Medicine Team.

So You Can't Get on with the People Under You*

By

MAJOR GENERAL THE REV. C. A. OSBORNE

In World War I Major General the Rev. C. A. Osborne served as subaltern in the British Army, and later was a lecturer in Tactics at the Royal Military College, Duntroon. Among other military appointments, he held the post of Field Marshal Lord Wavell's Director of Operations, when Lord Wavell was in India and Burma. General Osborne retired from the Army about eight years ago, took Holy Orders, and is now Assistant Minister at St. Mark's Church of England, Darling Point, Sydney, Australia.—EDITOR A.A.J.

I WAS not altogether surprised at the problem you write about in your letter. When we last met I suspected something of the kind was worrying you. I am only sorry we could not meet and talk it over now. But that isn't possible at the moment. You end your letter with these words, ". . . what it all boils down to is that I don't seem to be able to get on with the people under me. Can you make any suggestions?" Well, here are one or two thoughts from my own experience that may help you.

I think the basic difficulty in all these problems of personal relations is lack of imagination. So I suggest that you begin by trying to put yourself in the position of your subordinates. What would you like most to see in the make-up of the man over you?

To answer this question it is not necessary for me to go into any detail of your work—and anyway I don't know enough about it. It is sufficient to answer in principles and consider details later.

I think there are three qualities above all others that a man likes to see in his boss—efficiency, fair-mindedness and what I might call sympathy. Let's just think about these, remembering all the time that we must keep in the forefront of our minds the reaction of the subordinate—because it seems to me there is something in your habitual attitude that irritates him.

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EFFICIENCY

To take efficiency, I want to say three things—the first obvious, and the other not so obvious. If there is a side of your work in which you are inefficient, then you are unlikely to get much respect from your subordinates there until you make yourself efficient. You may be able to bluff someone over you; you can't consistently bluff someone under you.

The next point is, don't butt in unnecessarily. What I'm getting at is this—when a man is promoted he takes a wider responsibility. But he usually feels a pull towards his old job, and unless he is careful he is liable to take an undue critical interest in it—and thereby irritate his successor.

In wartime we are always hearing about colonels who tried to command every section in the unit. One of the things that efficiency calls for is decentralisation—letting each member of the team get on with his job in his own way provided he is doing it all right. And don't think that efficiency is entirely a matter of $^{a}R^{2}$. It includes efficiency in personal relations—and that is always far more difficult than any technical problem. That idea of teamwork is behind all I want to write on the other two thoughts—fair-mindedness and sympathy.

You remember the old parlor game "Animal, Vegetable, or Mineral?" It could be played with people (although it wouldn't be very popular)—because in their attitude to the job all men and women come within one of these three categories. There is the animal approach: "What can I get out of it?" There is the vegetable approach: "I just do my job and I don't want to be disturbed." There is the mineral approach: "What have I got that I can put into it?" The "Minerals" I might call them, are the most important people—the ones who are the most worth while.

FAIR-MINDEDNESS

All three types have one characteristic in common—they all like being appreciated—they all like feeling important in some way. As far as your problems are concerned, that means they like to feel their work is important. And that applies especially to the key-people—the "minerals."

Now I've found that the only way to ensure that everyone feels his job is important is for the head always to regard the whole show as teamwork. That doesn't mean you have to pretend every individual job is of equal importance. It does mean that nobody feels left out in the cold. It means, too, that you yourself understand that your own importance is due largely to their work. That keeps you from entertaining too high an opinion of yourself—and that is one of the things that intensely irritates subordinates.

Just watch your conversation in this respect. Keep your use of the personal pronoun down to the minimum—you know what I mean: "I think this . . ." "I do this . . ." "My Department does this . . ." It's a so much friendlier and less conceited way of talking to say "We think this," "We do this." Think how irritated you get when you hear a politician saying, "I did this . . ." "I did that." Well, the people under you have the same reaction to the same phrases.

So point number one under fair-mindedness is—always let the people under you see that you regard their work as important and give them credit for what they do. If you have a new idea you want to introduce, it often pays to suggest it indirectly, so that in the end one of them will put it forward as his own idea. No idea is absolutely original. The best ideas usually come out of chewing over other people's thoughts as well as your own.

Remember the advice of the writer of the psalm: "Cast your bread on the waters . . ." I like the modern version—"There's no limit to what a man can do if he doesn't mind who gets the credit." You may think your particular line of business too ruthless for that. But try it—and you'll be surprised.

LOVE OF POWER

While we're on this point, there's something else I'd like to mention. It is the subtle peril of love of power. No man is immune from that, whatever eminence he may attain. In fact, the higher a man gets the greater the danger. I know. I've worked under generals and bishops and cabinet ministers. I know you are very ambitious. There's nothing wrong in that. In fact, there's everything right in it. Without personal ambition a man achieves nothing. But keep it under control. Don't let it be obvious every time that you open your mouth. And don't let it dominate your mind. That is a matter of mental discipline.

Be honest in your thinking. Don't insist on your own wishes and your own point of view always having first place. If you have any say in choosing your own subordinates, don't always go for the "yes" man. I have two friends, both very important people, who could have achieved really great things in their own spheres had they only resisted the temptation that comes to all men in authority—to appoint people who always agree with them. I seem to remember Winston Churchill had something to say about that. Discipline yourself always to consider other viewpoints, and especially the viewpoint of those under you.

If I could put that another way, I would talk about loyalty. When you have people under you, remember that loyalty goes down as well as up. You can't be loyal to the best interests of your employer without being loyal to the welfare of those people who are under you.

SYMPATHY

Now I come to the third main quality I mentioned—Sympathy. Don't get me wrong over this. When I say sympathy, I don't mean anything sloppy or weak. I mean being considerate—trying to see things from the other man's point of view.

Not long ago the general manager of a fairly big industry showed me over their works. They had had a lot of industrial

trouble, strikes and so on, at one time, but since he took over several years ago there had been practically no friction between management and employees. When we had been around, he remarked: "We have no production problem here; our only problems are problems of persons." I asked him how he managed to tackle those so successfully. He replied: "Well, once I got to know the men and women we employ here it wasn't too difficult."

And that, of course, is the first step. Get to know the people under you. You probably think that's elementary. It is. But it's extraordinary how many men in positions of authority neglect it. They think they know them—but they don't. Even in such simple things as knowing their names.

That remarkable American philosopher, guide and friend, Dale Carnegie, says: "A man's name is to him the sweetest and most important sound in the English language." And I think he's about right. But learning names is only the beginning of getting to know people.

My experience is that the more you know about a man as an individual the more you are able to adopt towards him an attitude that will encourage good work and some enthusiasm for that work. I was trained always to keep a list of people under me and a few notes about them. In every body of men there will be the good-humored, the sulky, the hard-working, the lazy, the loyal, the grumbling, the shy—and all the other diversities of which human nature is capable. Some men like being joked with and can enjoy a joke against themselves; others are touchy and can't be joked with at all.

There is the hard-working fellow who is always all out to do his best; there is the other fellow who never starts to work until he has had two or three prods to get him going. But if you prod the hard-worker it will upset him.

Then there is the grumbler who is always grousing; and the opposite type who never grumbles unless there is something worth grousing about. He must be listened to when he makes a complaint. But remember—what is happening in his private life always has a big influence on the way a man sees things and behaves. I don't mean that you should pry into the private lives of people. But my experience is that it makes all the difference in the world if you can get to the stage where you can occasionally ask a man how his children are getting on at school—or how his orchids are doing.

Only last year or so I found a man I had to deal with a most difficult, scratchy person. Months later I heard that his wife had been desperately ill for a long time. Curiously enough, ever since I heard that I have found him quite helpful and easy to get on with. His wife is better—but I suspect it is my attitude that has changed.

Another very important point to watch is to praise good work. It's extraordinary how many of the people who criticise even the slightest fault, neglect to praise an improvement. And watch that you don't overlook the shy ones, who are inclined to draw into their shells when you appear. I don't mean you should go in for flattering people. Cheap praise merely cheapens the man who gives it. But a cheerful word of encouragement and appreciation when you see something well done heartens the people under you and stimulates good will all round. Many a successful man will tell you that his first step was when a word of praise from someone encouraged him to develop some latent gift of character or skill.

THE REPRIMAND

Another point I've found important in life is this. When you have occasion to reprimand an employee, always do it without hurting his pride unduly. Even if you don't think he deserves it, give him the chance of saving his face—wherever possible have the matter out with him away from other people, and above all, never make a man feel uncomfortable in front of others who work under him. You remember the old rule: "Never tick off an NCO in front of the men." The principle applies in all walks of life.

"OFF THE RECORD" TALKS

One last word under the heading of sympathy. I'm a great believer in what I might call "off the record" talks to give people an occasional chance to ventilate any little grievance they may have—without having to go through all the business of an official complaint. Such talks are not always easy to manage—often very delicate to handle—but they can serve a very valuable purpose and prevent little troubles from festering and growing into big issues.

I know that so far I've written as though your difficulties are all your own fault. But I realise quite well there is always something to be said on both sides. You wouldn't have got where you are if you weren't worth it. But I hope some of the points I've mentioned may help in your dealings with difficult characters under you—people who are jealous, or inexperienced, or exasperatingly inefficient —those for whom you need the extra ration of patience.

Systemic Skin Reaction Due to Benoquin Ointment

By
LOTHAR WIRTH, M.D.

THERE are, at times, valid reasons why pigmented spots should be removed. Without surgery or chemical destruction such lesions as freckles, generalized lentigines, berlock dermatitis, melasma in Addison's disease or of pregnancy may be erased by the application of Benoquin.

Benoquin interferes with the conversion of tyrosine to dopa and thus with the formation of melanin. As the interruption of this physiological process stops with the cessation of therapy, it is necessary for the maintenance of beneficial results that the application of Benoquin be continued, at least at intervals. This chemical is said to be innocuous whether taken internally or applied externally. The occurrence of some local reactions has been known since the introduction of Benoquin, a purified and finely dispersed preparation of monobenzyl ether of hydroquinone.[1] In such cases less frequent application of a more dilute preparation was tolerated and equally beneficial.[1]

In a review of the literature I find that in 174 cases in which Benoquin was used a generalized dermatitis did not occur.[1,2,3,4] The following case may, therefore, be the first one on record in which a systemic skin reaction followed the local application of Benoquin ointment.

A 60 year-old white male used Benoquin ointment for the treatment of a pigmented area, the size of a "quarter," over the left temple. Four weeks after he had started to rub this substance in twice daily, a skin eruption of the dermal type occurred, involving forehead, dorsum of the neck, face and dorsum of either hand. The patient discontinued therapy for about one month with complete clearance of the dermatitis. A restart of the therapy reproduced the generalized eruption within two days.

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EDITORIALS

Nurse's Service One of Art, Science, Faith

THE profession of nursing is a boon to humanity. Angels are not dressed in flowing robes and wings; they wear the simple white uniform of a nurse. No one on earth is more essential nor does anyone help so much in the healing of maladies than the nurse. Her presence in a sick room, as she quietly and efficiently goes about her assigned ministrations in behalf of the patient, is the answer to a prayer. She is a priestess at the altar of medicine, the physician's assistant, without whose co-operation the doctor can hardly function. She is the indispensable agent in the art and science of the conquest of disease.

A good nurse uplifts the spirit of her patient. She knows when to talk and when to keep silent. She understands the signs of fatigue and restlessness, of loneliness and despair. She is unobtrusive yet ever present to answer the call for her service. Always her patient's welfare comes first. Like a mother soothing her hurt child, she knows how to encourage and hearten a suffering soul. In the long, cruel hours of the night when a patient is overwhelmed with discomfort, losing his confidence in the coming of a better day, she is by his side to see him through the harsh vigil. And when the dawn comes and the fever abates and the pain is eased, she rejoices humbly and prays gratefully. For a nurse is a woman of faith in God since she knows that He is the Supreme Physician.

Women can be praised for manifold achievements. They can do great things in the world for the good of all. But never is woman a greater person than when she is the nurse. Let none of us ever take for granted these dedicated women, these unsung heroines in countless dramas of life versus death.

Nursing is a wonderful career for a girl to choose. For the contribution of the nurse is a blessing to herself and at the same time the fulfillment of one of mankind's constant needs.

DR. HYMAN JUDAH SCHACHTEL,
The Houston Post, August 30, 1956.

Thanksgiving

LET'S talk Turkey! This certainly is the month that such a subject is appropriate.

For months now the turkeys have been nourished to the point of obesity; they have been given a lot of freedom of the range while unknowingly they approach the day of captivity and death. Aren't we thankful that we are not turkeys, or does it really matter to turkeys?

But there is something that matters and something for which we should be thankful. We live under the Stars and Stripes. Let us be thankful for that. Yes, let us give thanks not only on Thanksgiving Day but every day of the year.

We, too, are nourished well, yes, many to the point of obesity. In a land of surpluses we can become indifferent to many problems which are vital to this freedom which we enjoy under those Stars and Stripes. Yet, it is this very freedom of thought and action, freedom of pursuing our chosen vocations, freedom of travel, and many other freedoms not enjoyed by those of many nations, which have contributed to those very surpluses that some deplore, and would be considered blessings by a number of other nations.

We grumble at the cost of living; we complain because there are not enough schools; we complain that there aren't enough doctors; we comment on the lack of hospital beds; we deplore the increased cost of automobiles. The American has many complaints it seems.

Now isn't it about time that we feel a little thankful to a generous God who has showered us with blessings?

AVAILABLE NOW

Mass Casualties—Principles Involved in Treatment. The 190 page reprint of the text material which appeared in the April 1956 issue of MILITARY MEDICINE.
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Around the World

(Ser. II, No. 3)

By

CLAUDIUS F. MAYER, M.D.

CORSICA has been plagued by endemic malaria since the 13th century days of the Saracens. The difficulties in controlling the disease were recently enlarged by the fact that North African troops of the French Army, on their way back to the homeland, were stationed at this Mediterranean island. Not only did they provide a source of recrudescence for malaria, but they also imported a new disease. The fresh waters of Corsica, and also of nearby Monaco, abound in gastropodes (genus *Bulinus*), suitable intermediary hosts for the worm of schistosomosis which, in its life cycle, passes with the urine of the *soldiers from North Africa,* who are afflicted *with bilharziasis,* into the water and the stomach of the snail.

In Italy it happened the first time that a *nun graduated as doctor of medicine* at the University of Torino. The subject of the doctorial thesis of Sister Noemi (known as Beatrice Passet to her friends in her former civilian life) was the comparative study of the methods of functional exploration of the heat-regulating action of the autonomic nervous system. The sister is a Catholic missionary of the Order of Consolata. She will serve as physician in a backward area of British East Africa.

During the period from January 1953 to January 1955 the Outpatient Department of the *Central Military Hospital at 's-Gravenhage* (The Hague) treated 69 cases of freshly acquired *venereal disease* in 67 patients. Most of them (63) had gonorrhea; there were also 3 cases of lymphogranulomatosis, but only 2 cases of syphilis (one of them a mixed infection), and one of chancroid. During the accounted two years the entire Netherlands Army and Air Force reported an astonishingly small total of 208 cases of venereal diseases.

Soldiers of the *Netherlands Army* will be provided with a *new all-purpose uniform* in 1958, as it has been revealed by the Dutch Minister of War. The new uniform will be essentially a modification of the American 3-layer cold-wet combat dress. It will give sufficient protection against the different climatic changes in Netherlands, too, while it won't interfere much with the normal heat regulation of the human body, or with the performance of the various field duties. Though very practical, the new uniform is not glamorously dressy.

With the winter at its doorstep, *London* may again fear the fog. During the past eight winters there were three incidents of dense fog which caused a sharp rise in the mortality rate. One occurred in November 1948; another *killing fog* descended in December 1952; and the latest one lasted from 4 to 6 January this year (1956), causing almost a thousand additional deaths in Greater London. The British Broadcasting Company has arranged a special *fog-warning service in industrial areas* so that plants can take precautionary measures to reduce the sulfur (SO_2) content of the air.

In its final report (1956) the Royal Commission on Marriage and Divorce suggested that acceptance by a wife of *artificial insemination* by a donor without her husband's consent is a ground for divorce. Indeed, such an act of the wife is considered an injury to the husband which, in its possible consequences, is as serious as that of adultery. The report also includes many other subjects of medical interest such as insanity and mental deficiency, sexual deviations of husband and wife, epilepsy, venereal diseases, etc., as grounds for nullity. Not so long ago, in his address to the delegates of the Second World Congress on Sterility and Fertility, Pope Pius also declared that artificial in-

semination, whether the semen comes from the husband or from an unknown donor, is *immoral and absolutely illicit* in the view of the Roman Catholic Church.

Medical education is now thoroughly reformed in Turkey. The first medical school of the country had been established in 1826 only, and it is still in existence in a modern form. Yet, the *teaching of medicine in Turkey* has a much longer history. The Seleucid Turks had built the first hospital for psychotics in Amasya in 1308; it was the *"Timarhane."* Special psychiatric departments had been also attached to the hospitals at Kayseri (Caesarea), Sivas, Divrik, and Tokat. Near the hospitals, possibly in the same building, there were special rooms reserved for theological schools and welfare activities. One of the earliest of such schools (*"medrese"*) opened in 1206 in the hospital at Kayseri where the building also served as a place for medical instruction and as a dormitory for students. Another medical school opened in 1217 at Sivas. Mohammed II is credited with the *foundation of medical schools* and hospitals in conquested Byzance. The present medical school of Istanbul has 2,210 students, and the yearly admission of new students is 330. Turkey has another medical school at Ankara. A third one will soon open at Izmir (Smyrna), while East Anatolia is also expecting a new university of her own.

Although *Israel* is no more than 8,000 sq. miles in extent, it displays every variety of *subtropical climate.* At the North, it has a swampy, malarious area; along the sea it has a narrow, very fertile land; in the interior there are hills of varying fertility of soil, while in the South there is a wide expanse of arid country. Almost 70% of the population of 2,000,000 settled in the three big towns of Tel Aviv, Jerusalem, and Haifa. Nutrition among the Israelites is largely on a fish and vegetable diet, and the incidence of mild nutritional anemia is very high among them. Five sixths of the people are of recent European origin, and one sixth is of oriental extraction. The *main communicable diseases* are therefore mostly European, such as diphtheria, infectious hepatitis, dysentery (amebic and bacillary), paratyphoid, scarlatina, poliomyelitis, and some malaria. Leishmaniasis and mosquito fever are almost extinguished by the use of DDT. The incidence of schistosomiasis was greatly increased by the arrival of heavily infected Yemenite masses. Malaria is chiefly confined to the area of the Hula Swamp in the North.

Egypt is called *the country of contrasts.* People who go visiting the land to see the relics of the ancient pharaohs will also be amused to find, side by side on the streets of Cairo, the modern Cadillac of the rich and the small donkey of the fellah, the exotic girls dressed in fabulous dreams of Paris and their poor relatives clad in rags and working for a few piasters a day. Yet, everywhere in Egypt there is the evidence of a tremendous effort to improve the welfare of the masses. The government has adopted the modern idea of prefabricated houses to help the crowded workers. Yet, there seems to be no end of the crowding. The *fertile Egypt* also has a very high rate of human births, and each year the population is growing by another half a million, regardless of the relatively high rate of mortality among infants. Advocates of the *birth control movement* found that it is not easy to instruct birth-control practices to the women of a country where a husband is wont to expell his wife without any legal procedure, and where the number of offspring is still being considered the best testimony of one's virility.

In the Mulago Hospital, Kampala, Uganda, *nobody died from coronary thrombosis* in recent years. In 6,500 necropsies on Africans, the pathologist not infrequently found minimal degrees of atheroma, but he could not demonstrate gross lesions in any artery. At all ages, most Africans in Uganda live on a low fat diet. A recent *Symposium on the Adrenal Glands in Africans* was held in Kampala where it was stated that the adrenal cortex is strikingly reduced in the majority of African necropsies. The retained growth of the adrenal cortex may be the

result of malnutrition. On the other hand, the low protein intake during the period of rapid growth in infancy may offer protection against the severe manifestations of atheroma, coronary disease, angina pectoris, cholelithiasis, essential hypertension, and rheumatoid arthritis.

Surveys during the past two decades in Eastern Nigeria showed that a formidable amount of leprosy existed in the region. As hundreds of roads were built and civilization rapidly invaded the area, the size of the population and the variety of diseases also became evident. For the control of leprosy, the *Nigeria Leprosy Service* was created in 1945. In comparison with other geographic areas, in Eastern Nigeria leprosy is a relatively mild disease. There are but few lepers seen with mutilations or serious complications. Severe infections are only a minority of the total. Frank leproma is hardly more than 10%, while the bulk of infections consists of tuberculoid leprosy of low intensity, producing very few lesions and little physical discomfort. In the three provinces of Onitsha, Owerri and Rivers, 30,630 lepers were treated in 1948, but by the end of 1954, the number dropped to 14,770, a decline of over 50%. A drop of such magnitude in such a short time is a most unusual phenomenon. One may justly wonder whether this proves that the recent Nigerian outbreak were an *acute epidemic of leprosy.*

Last Fall, John Wiles, a member of the South Rhodesian Society of Geologists, entered a Central African cave to explore the enormous guano deposits left there by bats. He advanced to a depth of about 145 meters, and thus, for some time he was in close contact with the huge bats and other fauna abiding in the insanitary cave. A few weeks later, before his return to South Africa, he was stricken with a *mysterious ailment resembling pneumonia* with pleurisy. A physician (Geoffrey Dean) of the Port Elisabeth Hospital, where the geologist was treated, suspected and proved that his patient's disease was *histoplasmosis.* Indeed, under proper medication with antibiotics the man recovered. This affair started the South African doctor to think. He recalled the series of deaths from a mysterious disease which a few decades ago occurred among noted Egyptologists. A total of 23 of the explorers of Egyptian antiquities lost their lives under very dramatic circumstances. Everyone of them had either entered the death chamber of Pharaoh Tutankhamen or touched his treasures. Now, the South African doctor's theory is that the pharaoh's tomb abounded in subterranean fungi some of which might have belonged to the genus *Histoplasma.* Those who first disturbed the ancient resting place of the king could not help inhaling the pathogenic fungi stirred up with the dust of excavations. Of course, in 1923, when the *series of Tutankhamen mysteries* started with the peculiar death of Lord Carnarvon, histoplasmosis was still a rare disease, almost unknown even to the medical world.

Mosquito fever, or pappataci disease is one of the constant *afflictions in Russia,* causing much trouble especially at those places where "special contingents" (slaves?) are forced to rebuild the villages and towns destroyed by the late war. Russian virologists succeeded recently in cultivating several strains of the pathogenic virus. At the Ivanovsky Virological Institute, under the direction of M. P. Chumakov, *a live-vaccine has been developed* for immunization. This vaccine (by Ananian) does not cause disease, but, as the experiments on large groups of people (ca. 69,000) had shown, it is able to produce an equally satisfactory degree of immunity against the Crimean, Armenian, and Tashkent strains of mosquito-fever virus.

The *First International Congress of Human Genetics* successfully ended. It was held from 1 to 6 August, 1955, at København, with the participation of many. It is difficult to give in a nutshell an appraisal of this important congress which heard more than 250 scientific papers, and saw many interesting demonstrations and films. Some of the main topics of discussion were such as the effect of radiation on the increase of human mutations, degenerative effect of cousin mar-

riages, mysteries of twinning, detection of genetic carriers of recessive genes, antenatal determination of sex, correlation of blood groups and disease, and the question of somatic mosaicism.

Antenatal sexing, as it was shown, is now quite reliable by the examination of cells in the amniotic fluid (*Fuchs' method*). A Spaniard proved that the true *number of human chromosomes* is 46 instead of 48, as held until now. The corrections of his account was also confirmed by English geneticists who moreover stated that the total *length of the human chromosomes* was "27 morgan units" (i.e., half as long as the mouse chromosomes). Many papers of the congress pointed out the earlier and the more recently established correlations between certain *blood groups and special diseases.* Thus, many group-A persons were found among the sufferers from gastric cancer or pernicious anemia. The next international meeting of the human geneticists will be held in 1961.

Argentina became the harbor of Nazi refugees. One of them, a certain Friedrich Lenz, published a book under the title *"Adolf Hitler—Sein Kampf gegen die Minusseele."* The last word of the title means "negative soul," and anyone who fights old-time Naziism is such a soul in the opinion of Herr Lenz. The book was smuggled into Germany where it could be ordered for 10 RM (marks) at the address of a certain Frau at Berchtesgaden. The Supreme Court of Germany seized the work, however, in protection of the new legal institutions of the German Republic.

At the Southern border of the U.S., there is a mixed *Mexican-U.S. Frontier Association of Public Health* which is devoted to the solution of health problems arising peculiarly at the frontier lines of countries only. Among such mutual problems is the one of how to control venereal diseases spread by the *sexual promiscuity* that does not recognize geographical limits. In a recent address one of the health officers, engaged in the control program, emphasized the importance of contact investigations. As an illustration, to prove his point, he quoted the four most typical cases of *recent epidemics of syphilis* and chancroid observed in the U.S.: 1) in Kentucky (70 contacts, 24 syphilitics); 2) in North Carolina (101 contacts, 29 syphilitics); 3) in Virginia (1 girl with 41 male contacts, 23 infected with chancroid), and 4) in Georgia (211 contacts, 71 syphilitics).—*Multa paucis.*

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ASSOCIATION NOTES

Timely items of general interest are accepted for these columns. Deadline is 3rd of month preceding month of issue.

Department of Defense

Ass't Secretary (Health & Medical)—HON. FRANK B. BERRY, M.D.
Deputy Ass't Sec'y—HON. EDW. H. CUSHING, M.D.

NATIONAL LIBRARY OF MEDICINE

On October 1 the Armed Forces Medical Library was transferred to the Department of Health, Education, and Welfare. It will now be known as the National Library of Medicine.

Col. Frank B. Rogers, MC, U. S. Army, who has been director of the library will remain in the same position, being detailed by the Army to duty with the U. S. Public Health Service, the new operating agency.

MEDICAL CARE PROGRAM

Maj. General Paul I. Robinson, MC, U. S. Army, has been appointed Executive Director of the new dependents' care program which has been established as a result of the Dependent Care Act (Public Law 569, 84th Congress).

The Army has been designated as the agency to operate the program for this medical care for dependents of the Army, Navy, Air Force, Public Health Service, Coast and Geodetic Survey, and the Coast Guard.

General Robinson comes to the new assignment from San Francisco where he has been in command of the Letterman General Hospital. He has had a broad experience in the Office of the Surgeon General in the Finance and Supply Division and the Personnel Division. He has seen service in Hawaii, Europe, the South Pacific, and Korea since entering the Army in 1928.

Army Photo

MAJ. GEN. PAUL I. ROBINSON, MC, USA

There will be many problems involved in this new program from the making of contracts to the payment of claims. The task is a tremendous one and will involve the expenditure of millions of dollars.

PAMPHLET AVAILABLE

Buying Life Insurance is a pamphlet available for members of the Armed Forces who desire to purchase commercial life insurance. It is now being distributed by unit insurance counselors.

Army

Surgeon General—MAJ. GEN. SILAS B. HAYS
Deputy Surg. Gen.—MAJ. GEN. JAMES P. COONEY

INSTITUTE OF REGISTRARS

Major General James P. Cooney, Deputy Surgeon General of the Army, welcomed sixty-five military and civilian registrars or their staff associates from almost all the Army hospitals in the United States and from Europe, Japan, Hawaii and Puerto Rico to participation in the one-week Institute of Registrars conducted by the Medical Statistics Division of the Surgeon General's Office at Walter Reed Army Medical Center, October 8-13.

The purpose of this Institute was to provide orientation on the many recent actual and scheduled changes in the Army's method of keeping medical records and reports. A new health record system becomes effective January 1, 1957.

The course director for the Institute was Eugene L. Hamilton, Chief of the Medical Statistics Division of the Surgeon Generals' Office.

NURSES CONFERENCE

The Chief of the Army Nurse Corps, Colonel Inez Hayes, has arranged for a conference of chief nurses for November 5-7 in the Office of the Surgeon General. The conference is designed to provide discussion, analysis and further planning in the all important subject of in-service education and training for professional and non-professional nursing service personnel.

ARMY STUDENT NURSE PROGRAM

Juniors and seniors in schools of nursing from coast to coast in the United States are accepting appointment in the new Student Nurse Program of the Army Medical Service as their first steps towards becoming members of the Army Nurse Corps.

When they have been graduated in 1957 or 1958 and have been certified as RNs by their respective states, they will be commissioned as second lieutenants in the Army Nurse Corps and be assigned to active duty as officers for a two or three year period. Students in the three-year schools must be seniors and those in the four-year schools are eligible if they have completed two years of the course and will serve in the Army a year longer than those completing their studies in the shorter period.

In the meantime they will receive the pay and allowances of an enlisted Reserve on active duty in the Women's Army Corps (about $200 monthly) to defray the cost of completing their basic nursing program. No participation in military activities is required during the schooling.

The Army Student Nurse Program was put into effect in April 1956 as an aid to meeting the long-range needs of the Army Nurse Corps as well as those of the nation. It is designed to enable selected students of proven ability to complete their nursing education with financial assistance.

To be eligible for selection under the program, an applicant must be a citizen of the United States, 18 years of age but not to have attained her 28th birthday, possess high personal, scholastic and moral qualifications and be matriculated as a full time student in a three or four year nursing course leading to a diploma or a bachelor's degree in nursing.

NURSE TRAINEE

Under the Army Student Nurse program sponsored by the Army Medical Service to procure personnel for the Army Nurse Corps, Pvt. Celestine B. Leary, WAC, who is a junior in the School of Nursing, Catholic University of America, Washington, D.C., will receive approximately $200 per month for two years. After her graduation she will become Lt. Leary (1958) with three years of obligated service in the Army Nurse Corps.

NAVY CORPSMAN BECOMES ARMY NURSE

It is now Second Lieutenant Thomas J. Wetsch, Army Nurse Corps Reserve rather than Hospital Corpsman Wetsch, Third Class, U. S. Navy. Such was the change made possible for this male nurse by legislation implemented a year ago to admit male nurses to the Army Medical Service.

Lt. Wetsch was graduated from the St. Alexius Hospital School of Nursing, Bis-

marck, N.D., in 1954 and was the first male registered nurse in that State. He is now on duty at the U. S. Army Disciplinary Barracks, Lompoc, Calif.

SGO ASSIGNMENTS

Col. Albert J. Glass, MC, has been appointed Chief, Office of Psychiatry and Neurology Consultant, in the Professional Division of the Office of the Surgeon General. Colonel Glass has contributed extensively to medical literature on the subject of combat psychiatry.

Col. Francis W. Regnier, MC, has been assigned as Assistant Chief of the Education and Training Division in the Office of the Surgeon General. He was formerly Chief of the Professional Standards Division and Executive Officer of the Medical Section, 2nd Army Headquarters, Fort Meade, Md.

Lt. Colonel Spurgeon H. Neel, MC, has been assigned as Chief, Army Aviation Branch in the Office of the Surgeon General of the Army. He is a graduate of the School of Aviation Medicine, Randolph Field, Texas. He has been surgeon of the 82nd Airborne Division and Commanding Officer of the 30th Medical Group (Korea) during his Army career.

Major Elias M. Throne, MC, has been assigned as Chief, Professional Training Branch, Education and Training Division, in the Surgeon General's Office. He replaces Major Varner J. Johns, MC, who has returned to the College of Medical Evangelists in Los Angeles where he will be Associate Professor and Dean of Medicine in the Medical School.

ASSIGNMENT WRAH

Lt. Col. Aniello F. Mastellone, MC, has been assigned as Chief of the Physical Medicine Service, Walter Reed Army Hospital. He replaces Col. Harold B. Luscombe, MC, who retired from the service.

LEAVES BROOKE MEDICAL CENTER

Lt. Colonel Curtis P. Artz, MC, who was Commander of the Surgical Research Unit, Brooke Army Medical Center, Fort Sam Houston, Texas, has left the Army to become professor of surgery at the University of Mississippi, Jackson, Miss.

Colonel Artz, a graduate of Ohio State University, entered the Army Medical Corps in 1948 after two years surgical residency at that university. He was assigned to the Brooke Army Medical Center. During the Korean Conflict he was with the Surgical Research Team, and in 1953 succeeded to the command of the Surgical Research Unit.

His work with the research unit has made him one of the nation's leading authorities on the treatment of burns. He, with other staff members of his group, has written extensively on the subject and produced eight motion pictures, four of which have been accepted by the American College of Surgeons.

MEDICAL SERVICE SCHOOL

Lt. Col. Richard M. Parker has assumed duty as commanding officer of the Army Medical Service School's First Battalion. He replaced Lt. Col. Foster Watts. In this assignment he has command of approximately 1000 enlisted men and officers in administrative positions at the school and troops used in demonstrations of field medical procedures for officer students.

Lt. Colonel Leon J. Carrington and Captain William E. Castleberry, Jr., have been assigned to the Department of Training Doctrine at the Army Medical Service School.

Captains Donald D. Fetzer and Wallace Nichols, Jr., and Second Lieutenant Robert J. Muzzio have been assigned as instructors in preventive medicine at the Army Medical Service School.

Captain John W. Mills will instruct in the Department of Medicine and Surgery; and Second Lieutenant Lester H. Dacus will be assistant Schedules Officer in the Operations Division of the School.

CASUALTY TEST AT BAMC

The Army Medical Service School prepared 1,000 "casualty" cards designating the "injuries" which were to be treated in the

mass casualty exercise at the Brooke Army Hospital, Fort Sam Houston, Texas, September 13 and 14.

The Headquarters of the Medical Center planned the exercise which simulated a tornado followed by fire.

FIRST ARMY ASSIGNMENT

Colonel Raymond Maret, MC, formerly of Washington, D.C., has been assigned as Chief of the Professional Services Division, Medical Section, First Army. He replaces Lt. Col. R. C. Stokes who has been ordered overseas.

HONORED

Brig. General Neal Harper, U. S. A., Retired, was chosen as Doctor of the Year by the 1956 graduating class of the Ohio State University College of Dentistry where he is a faculty member.

Lt. Col. William H. Crosby, Chief of the Walter Reed Army Institute of Research, Department of Hematology, had conferred upon him recently at the Cuban Embassy, Washington, the National Order of Merit "Carlos J. Finlay." During the presentation by the Cuban Ambassador, Dr. Miguel Angel Campa, Colonel Crosby was commended for his internationally important contributions in the field of hematology by Dr. Moises Chediak, Director of the Institute of Hygiene, Havana, Cuba.

Colonel Crosby is the second American Medical Corps officer to be made a member of the National Order.

ADVISORY COMMITTEE

Col. Joseph L. Bernier, DC, Chief of Oral Pathology Branch, Armed Forces Institute of Pathology, and Chairman of the Dental Research Advisory Committee to the Office of the Surgeon General, met with the committee on October 4 and 5 for the purpose of considering requests for the support of research from Department of the Army funds by civilian agencies and individuals.

RETIRED

Brig. General William L. Wilson, MC, who has been commanding the Madigan General Hospital, Tacoma, Wash., retired from the Army on September 30 after more than 30 years of active service in the Army Medical Corps.

REGULAR ARMY OFFICER CORPS

Augmentation of the Regular Army Officer Corps authorized by Public Law 737, 84th Congress, is now under way.

The Law provides for the appointment of Regular Army officers above the grade of first lieutenant. The Army plans to make appointments only in grades below that of general officer.

Although the law authorizes the increasing of the commissioned ranks from 30,600 to 49,500 the following goals have been approved by the Secretary of Defense and the President: (1) 72% of statutory authorization or 35,640 by July 1958, (2) 80% of authorization, or 39,600 by 1963.

Any officer appointed must be of such an age that he can complete twenty years of active commissioned service before his 55th birthday. Except for veterinarians, chaplains, judge advocates and Medical Service Corps officers (for whom provisions of previous laws and policy continue to apply), the maximum age for appointment with no promotion list credit is twenty-seven. This age may be increased by the amount of promotion list service credited at appointment.

Not over 200 specialists in critical fields will be given certain credits allowed under the Law.

Applications are now being received by the Army.

ARMY SONG

It will not be "The Caissons Go Rolling Along" any more, but the tune will be the same. The new Army song to be officially dedicated on Veterans Day, November 11, will be "The Army Goes Rolling Along."

Navy

Surgeon General—Rear Adm. Bartholomew W. Hogan

Deputy Surgeon General—Rear Admiral Bruce E. Bradley

FLAG OFFICER CHANGES

Rear Admiral Thomas F. Cooper, MC, has assumed command of the National Naval Medical Center at Bethesda, Maryland. Admiral Cooper had been Inspector General, Medical Department activities, Department of Navy.

Rear Admiral Frank P. Gilmore, MC, has been named to be Assistant Chief, Bureau of Medicine and Surgery, for Planning and Logistics.

Rear Admiral French R. Moore, MC, has been appointed as Inspector General, Medical Department activities, Department of Navy.

Captain Clifford C. DeFord, DC, selected for promotion to the rank of rear admiral, has been designated as Inspector, Naval Dental Activities, Atlantic Coast, with additional duty as the Third Naval District dental officer.

TECHNICAL DIRECTOR, NMRI

Dr. Ralph S. Muckenfuss, a native of Mississippi, has recently joined the staff of the Naval Medical Research Institute, Bethesda, Maryland, as Technical Director.

He received his medical degree from Emory University and after internship at the Philadelphia General Hospital joined the Rockefeller Institute as Assistant in Bacteriology. During World War II he was Commanding Officer of the 1st Medical General Laboratory of the Army and served in the European Theater.

BUMED ASSIGNMENT

Capt. Guy E. Stahr, MC, has been assigned as Head of the newly established office dealing with Dependent Medical Care, Bureau of Medicine and Surgery. Prior to this assignment Capt. Stahr was Commanding Officer of the U. S. Naval Medical School, Bethesda, Maryland.

ASSIGNMENTS

Captain Calvin B. Galloway, MC, assumed command of the Naval Medical School, National Naval Medical Center, on September 5. He recently returned from Cairo, Egypt, where he was Commanding Officer of the Naval Medical Research Unit No. 3.

Capt. Galloway is a graduate of the University of Michigan (1930) and did his internship in the Navy. He served with the Second Marine Division during World War II in the operation against Okinawa.

Captain Benjamin G. Feen, MC, has assumed duties as Executive Officer of the Naval Hospital at Philadelphia. Prior to assuming this duty he was Force Medical Officer, Commander Service Force, U. S. Pacific Fleet at Pearl Harbor.

Commander Herman B. Tidwell, MSC, has assumed duties as Administrative Officer, National Naval Medical Center, Bethesda, Maryland. He had been located at the Naval Training Center, San Diego, Calif.

POSTGRADUATE DENTAL CLASS

There are twenty-four Dental Corps officers enrolled in the General Postgraduate Class which is to be graduated at the Naval Dental School, Bethesda, Maryland in June, 1957. The officers are: Commanders James J. Brown, John F. Bucher, Frank Dobronte, A. E. Gustavson, Theodore R. Hunley, T. H. Mayo, and Robert M. Williams; Lieutenant Commanders L. M. Armstrong, M. L. Calton, B. Chap, F. D. Grossman, E. F. Jones, R. R. Perkins, and M. Zustiak; Lieutenants Lee A. Counsell, Paul E. Farrell, Harold N. Glasser, James W. Hays, Jack D. Mahoney, Clifford H. Prince, W. E. Ralls, W. B. Shreve, P. J. Sydow and M. E. Wortham.

RETIRED

Captain David W. Lyon, Jr., MC, retired on September 1 after more than 31 years active service. His temporary address is 2828 Connecticut Ave., N.W., Washington, D.C. His permanent address is 220 W. 12th St., Claremont, Calif.

Captain Fay O. Huntsinger, MSC, retired on September 1 after completing more than 40 years active service in the Navy. His permanent address is Freeport, Indiana.

Commander Paul R. Cox, MSC, who has

been Administrative Officer at the National Naval Medical Center, Bethesda, Md., retired on October 1.

CORRESPONDENCE COURSES

Medical Department personnel, other than Dental Department personnel, desiring enrollment in a Medical Department correspondence course should address applications to the Commanding Officer, U. S. Naval Medical School, National Naval Medical Center, Bethesda 14, Maryland. Applications must be sent through official channels on form NavPers 992 (Revised 2-56).

The Medical Department correspondence cource, *Clinical Laboratory Procedures, NavPers 10994,* is available to eligible Regular and Reserve officers and enlisted personnel of the Medical Department.

This course is of the objective question type, designed to furnish enrollees a concise guide and ready reference to intricate clinical laboratory procedures. It provides information by which Medical Department personnel may acquaint and familiarize themselves with the latest methods and most efficient steps to follow in the performance of various clinical laboratory and biochemistry procedures. The clinical laboratory and biochemistry procedures contained in this course are for use in the field as well as in naval hospital laboratories.

Consisting of eight parts, it is evaluated at 24 promotion and non-disability retirement points.

Air Force

Surgeon General—MAJ. GEN. DAN C. OGLE
Deputy Surg. Gen.—MAJ. GEN. W. H. POWELL, JR.

HOSPITAL DEDICATION

Major General Dan C. Ogle, Surgeon General of the Air Force delivered an address at the dedication of the new hospital at Wright-Patterson Air Force Base, Dayton, Ohio, September 21, 1956. In that address General Ogle stated: "The broad fields of medicine have long been identified with peace. Peace which as a collective term signifies freedom from depressions of the spirit, freedom from fears and weaknesses, freedom from sickness and disability, and freedom from pain and the fear of death. Such personal freedoms as these provide peace for the individual, and I can think of no higher dedication for this hospital, for its staff, or for our whole Medical Service than that we make such inner peace possible for individual men and women of the Air Force who are themselves collectively dedicated to preserving the same freedoms for the whole nation."

GRADUATE DEGREES

The Master of Public Health degree was conferred upon five Air Force veterinary officers in June. The University of Michigan conferred the degree on Maj. Edward P. Hornickel, Captains Donald O. Houk, and William H. Grau, Jr. The degree was conferred on Capt. Donald W. Ringley by the University of California; Johns Hopkins University conferred the degree on Captain William V. Howells.

The Master's Degree in Medical Physics and Radiation Biology was conferred on Capt. Richard E. Benson by the University of Rochester, New York.

DOCTOR-PILOT

A pilot-doctor, Major Louis F. Johnson, Jr., is attending the Advanced Course at the School of Aviation Medicine, Randolph Air Force Base, Texas.

Major Johnson has had a lot of experience in flying. During World War II he was flying Air Transport Command runs across the North Atlantic.

After the war he returned to medical school and obtained his medical degree in 1949 but kept on flying with a Reserve unit. Then he went to Korea as a pilot in 1951.

He returned to the practice of medicine but had the flying urge and the desire to become proficient in the specialty of avia-

tion medicine. So back to the Air Force he came. Now he is getting not only further medical training but jet pilot training.

Public Health Service

Surgeon General—LEROY E. BURNEY, M.D.
Deputy Surg. Gen.—W. PALMER DEARING, M.D.

ADVISORY COUNCIL APPOINTED

The Secretary of Health, Education, and Welfare, Marion B. Folsom, recently appointed a 12-member advisory council to assist the Public Health Service in administering a new program of Federal grants for construction of medical research facilities.

Those appointed were: Dr. George N. Aagaard (University of Washington); Eugene N. Beesley (President, Eli Lilly & Co.); Dr. Thomas H. Hunter (University of Virginia); Dr. Carlyle Jacobsen (State University of New York); Dr. Paul C. Kitchin (Ohio State University); Dr. Oliver H. Lowry (Washington University); Dr. Robert A. Moore (University of Pittsburgh); F. C. Sowell (Manager Radio Station WLAC, Nashville, Tenn.); Dr. John E. W. Sterling (Stanford University); Dr. Thomas B. Turner (Johns Hopkins University); Dr. James W. Wilson (Brown University); James Bradshaw Mintener (former Ass't. Sec'y., Dep't. Health, Education, and Welfare).

GRANTS FOR RESEARCH FACILITIES

More than 250 institutions have asked for information and application forms for construction grants for research facilities authorized by the 84th Congress. The $90-million program provides assistance on a 50-50 matching basis for building and equipping research facilities in the fields of medicine, osteopathy, dentistry, public health, and related health sciences.

All applications are reviewed by the National Advisory Council on Health Research facilities, Department Health, Education, and Welfare.

DENTAL COUNCIL MEMBERS

Dr. Thomas W. Clune, Director of Dental Public Health, Rhode Island Department of Health, has been appointed to serve on the National Advisory Dental Research Council. The Council advises the Surgeon General of the Public Health Service regarding activities carried out under the sponsorship of the National Institute of Dental Research.

Dr. J. R. Blayney, Emeritus Professor of Dental Surgery and former Director of the Walter G. Zoller Memorial Dental Clinic, University of Chicago, has also been appointed to serve on the National Advisory Dental Research Council.

PUBLIC HEALTH TRAINING PROGRAM

Under a program authorized by Congress on July 23, the Public Health Service has awarded almost $1 million to schools and individuals for the training of public health workers.

The individuals being trained will for the most part be employed in state and local health departments in an effort to overcome the critical shortage of personnel in the field of public health.

ASSIGNMENT

Dr. John D. Porterfield has been named Assistant to the Surgeon General of the Public Health Service. He will have responsibility in planning and developing new programs and will give particular attention to the fields of chronic diseases and aging.

He has been with the Public Health Service since 1939 and has had a broad experience in the field of preventive medicine.

ATHEROSCLEROSIS

The study of atherosclerosis and the implication of the lipoproteins as a causative factor is not new. However there have been new developments in the field at the National Institutes of Health.

Drs. Joseph Bragdon, Edwin Boyle, and Richard Havel, researchers at the National

Heart Institute have reported some interesting developments in their study of the human lipoproteins and have reported their findings in the *Journal of Laboratory and Clinical Medicine.*

In substance they report four "fractions" on the basis of density by using the ultracentrifuge. After the injection of these fractions in male rats they found abnormal deposits of fatty material on the valves and inner linings of the hearts and in the coronary arteries of the rats that received fractions one, two and three. Fraction four produced no such abnormalities.

It has been pointed out that the blood plasma of men generally contains a higher proportion of these suspect fractions than that of women, and nearly twice as many men as women die of atherosclerotic heart disease.

CORONARY HEART DISEASE

In a survey made by the Public Health Service it was shown that coronary heart disease causes about a third of all deaths among white males in the age group 45 to 74, and about a fifth among men 35 to 44.

States recording the lowest death rates for coronary disease among white males of all ages in 1950 were New Mexico, Arkansas, and Kentucky. Female rates for white population showed a considerably lower rate in all States, with the lowest rates being in New Mexico, Arizona, and Nebraska.

Rates for white males were highest in New York, Rhode Island, and the District of Columbia; rates for white females were highest in New York, New Jersey, and Rhode Island.

IMMUNIZATION INFORMATION

Immunization Information for International Travel is a 61-page booklet giving information about immunizations required by the various countries. Also listed are the yellow fever vaccination centers.

The booklet is available at 25¢ per copy from the Superintendent of Documents, Government Printing Office, Washington 25, D.C.

Veterans Administration

Chief Medical Director—WILLIAM S. MIDDLETON, M.D.

Deputy Chief Med. Dir.—R. A. WOLFORD, M.D.

ADVISORY GROUP MEMBER

Four new members have accepted appointments to the Veterans Administration Special Medical Advisory Group which meets quarterly to advise the Administrator of Veterans Affairs and the Chief Medical Director. They are: Dr. Charles D. Shields, Professor and Director of the Department of Physical Medicine and Rehabilitation at Georgetown University; Dr. Howard P. Rome, Department of Psychiatry of the Mayo Clinic; Dr. Shields Warren of the Cancer Research Institute, New England Deaconess Hospital; and Mrs. Marion Sheahan Bailey, Associate General Director of the National League for Nursing, Inc.

ASSIGNMENT

George D. Frye, the first graduate in occupational therapy from the University of Iowa Medical School, will head the world's largest occupational therapy program, that of the Veterans Administration. He will be at the Central Office in Washington, D.C.

Mr. Frye is a combat veteran of the Marine Corps in World War II, and now holds the rank of captain in the Marine Corps reserves. In 1939 he played center on the University of Iowa's "iron man" football team.

Bernard M. Anderman, Ed.D., has been appointed chief of audiology and speech correction in the Veterans Administration Department of Medicine and Surgery at Washington, D.C. Dr. Anderman was a contributing author to the recently published text book, "Functional Otology."

COMPENSATION CASES REVIEWED

More than 95 per cent of the 572,800 compensation and pension claims of veterans which have undergone a comprehensive review were accurate and required no

adjustment according to the Veterans Administration.

The review eventually will cover 1,713,000 cases in which World War II or peacetime veterans under 55 years of age are receiving compensation for service-connected disabilities.

National Guard

ORGANIZATION DAY

The Seventh Annual Organization Day of the 83rd Medical Group, Pennsylvania National Guard was held on September 10 at the Wellsboro Armory, Wellsboro, Pa. The affair which was said to be the best ever was attended by 115 Guardsmen and their guests.

The speaker of the evening was Colonel Richard Snyder, Deputy Adjutant General of Pennsylvania, who spoke on the subject "Leadership." The last Commanding Officer of the pre-World War II Company of National Guard of Wellsboro, Lt. Colonel William F. White, was introduced by Colonel Archibald Laird.

Miscellaneous

POLIO FOUNDATION NEWS

Dr. Hart E. Van Riper, Medical Director of the National Foundation for Infantile Paralysis since 1946, has left that Foundation to become Medical Director of Geigy Pharmaceuticals, Division of Geigy Chemical Corporation.

Dr. Thomas M. Rivers of New York City, formerly vice president of the Rockefeller Institute for Medical Research, has been appointed Medical Director of the National Foundation for Infantile Paralysis to replace Dr. Van Riper.

Dr. Rivers obtained his medical degree in 1915 at Johns Hopkins University. He served in the Navy in World Wars I and II and attained the rank of rear admiral in the Navy Medical Corps Reserve. He is widely known for his work in virology. He is author of "Viral and Rickettsial Infections of Man."

FEDERAL HOSPITAL INSTITUTE ALUMNI ASSOCIATION

Reuben Cohen, manager of the Veterans Administration Center at Kecoughtan, Va., was named president of the Federal Hospital Institute Alumni Association at the organization's annual breakfast September 18 at the Palmer House, Chicago, Ill.

Nearly 100 guests attended the breakfast. Frank B. Berry, M.D., the Assistant Secretary of Defense (Health and Medical) spoke on "Implementing the Dependents' Care Law."

The objects of the Association are to promote and develop an association composed of Federal Hospital Administrators; to improve the competency of Federal Hospital Administrators; to provide a central source of information concerning Federal Hospital Administrators; to familiarize other recognized hospital groups with the competence of Federal Hospital Administrators, and to act as sponsor of the publication of articles on administration activities when developed by Federal Hospital Association members.

Other officers are: Col. Everett Chalker, USAF (MC), Selfridge Air Force Base, Mich., First Vice-president; Col. Arthur H. Corliss, USAF (MC), Mitchell Air Force Base, N.Y., 2nd Vice-president; N. E. Lindquist, Administration Officer, USPHS hospital, Lexington, Ky., Secretary.

ARMED FORCES WRITER'S LEAGUE

There is a new National organization of service connected writers who stand ready to give a helping hand to service personnel (including dependents) who are free lance writers or who would like to break into print.

The League has as its special mission the promoting of writing and illustrating for publication by members of the Armed Forces and others associated with the Armed Forces, and the assisting of such members in producing and selling their material. Membership at one dollar a year or ten dol-

lars for life is available to all members of the Armed Forces, active or retired, including Reservists, both active and inactive, and their dependents. Veterans, civilian employees and others without a direct service connection may enroll as associate members.

For further information address R. S. Ewing, National Secretary, Armed Forces Writer's League, 2542 No. Utah St., Arlington 7, Va.

INFECTIOUS HEPATITIS RESEARCH AWARD

Dr. J. Garrott Allen, professor of surgery at the University of Chicago, recently won the John Elliot Award of the American Association of Blood Banks for his research work demonstrating that infectious hepatitis can not be transmitted by liquid blood plasma which is stored at warm room temperatures for six months or longer.

Dr. Allen showed that the virus of infectious hepatitis is killed by plasma storage at temperatures in the range of about 90 degrees, Fahrenheit.

FELLOWSHIPS

The Medical Section of the National Tuberculosis Association, the American Trudeau Society, offers a limited number of fellowships to promote the training of clinicians, medical teachers and scientific investigators in the field of tuberculosis and respiratory diseases. Applications must be received by January 1, 1957. Information pertaining to these fellowships may be obtained from The Director of Medical Education, American Trudeau Society, c/o The Henry Phipps Institute, Seventh and Lombard Sts., Philadelphia 47, Pa.

Special Fellowships in Industrial Medicine for the Academic Year 1957-58 are being offered by the U. S. Atomic Energy Commission.

The Fellowships are open to men and women physicians who are citizens of the United States, and who have graduated from an approved College of Medicine at least two years prior to the beginning tenure of the Fellowship. They must be licensed in one of the States or Territories of the United States. The stipend is $3,600.

Inquiries should be addressed to: A. E. C. Fellowships in Industrial Medicine, Atomic Energy Project, University of Rochester, School of Medicine and Dentistry, Rochester 20, N.Y., Attention: Dr. Henry A. Blair.

DERMATOLOGY FELLOWSHIPS

A number of dermatologic research and teaching fellowships are available at the New York Skin and Cancer Unit of the New York University-Bellevue Medical Center.

These fellowships are available on two levels. One is for dermatologists who have completed their three-year, full time training in dermatology and who are desirous of embarking on research. This fellowship pays $7,000 a year.

The second type of fellowship is available to graduate students or residents who have completed their basic science year at a recognized institution and who plan to do research or to assist in teaching in special fields. This fellowship pays $5,000 a year.

Applicants should apply to: The Director, Service of Dermatology, New York Skin and Cancer Unit, 330 Second Ave., New York 3, N.Y.

SCHOLARSHIP

The Cleveland Health Museum which specializes in visual aids for patient education has established the Lester Taylor Memorial Scholarship of $500 for a qualified graduate interested in: (1) school health education, (2) visual methods in health education, and (3) educational work in museums. Applications should be addressed to Bruno Gebhard, M.D., Director, Cleveland Health Museum, 8911 Euclid, Cleveland 6, Ohio.

LECTURE ON OVERWEIGHT

The A. Walter Suiter Lecture will be given at a meeting of The New York Academy of Medicine in Hosack Hall at 8:30 P.M., December 6.

The subject of overweight will be discussed by Jean Mayer, Sc.D., Ph.D., Associate Professor of Nutrition, Harvard School of Public Health; Dr. John R. Brobeck, Professor and Chairman of the Department of Physiology, University of Pennsylvania; and Dr. Walter W. Hamburger, Associate Professor of Psychiatry, University of Rochester.

PANAMA MEDICAL CONVENTION

The Second Inter-American Medical Convention will be held in Panama City, Panama, April 3, 4, and 5, 1957.

This convention is being sponsored by the Medical Society of the Isthmian Canal Zone. Papers will be in English and Spanish with translations in both languages. All physicians are invited. Further information may be obtained by addressing William T. Bailey, M.D., Chairman, Executive Committee, Box "E," Balboa Heights, C.Z.

BAHAMAS MEDICAL CONFERENCE

The Bahamas Medical Conference will be held in Nassau December 1-15, 1956. Reservations and travel arrangements should be made through the Allen Travel Service, Inc., 550 Fifth Ave., New York 36, N.Y.

JAPAN MEDICAL CONGRESS

Proceedings of the XIV Japan Medical Congress, held April 1-5, 1955, in Kyoto, Japan, are available at $6.00 prepaid. Orders should be sent to: The Bureau of Archives, The XIV Japan Medical Congress, Department of Pathology, Faculty of Medicine, Kyoto University, Yoshida, Skayo-ku, Kyoto, Japan.

Part I contains 394 pages; Part II, 340 pages. The articles are in English, German, and French, and cover all fields of medicine.

PRESCRIPTION LEAFLET AVAILABLE

Your Prescription is the title of a leaflet designed for distribution by pharmacists. These leaflets are available from the Prescription Division, Owens-Illinois Glass Co., P.O. Box 1035, Toledo 1, Ohio.

CHRONIC ILLNESS GUIDE

Guides to Action on Chronic Illness is an 88-page book which is available for $1 from the National Health Council, 1790 Broadway, New York 19, N.Y.

PAMPHLETS AVAILABLE

Safe Practice for Hospital Operating Rooms, NFPA pamphlet No. 56 (price 25¢), and *Standards for Nonflammable Medical Gas Systems,* NFPA No. 565 (price 35¢) are available from the National Fire Protection Association, 60 Batterymarch St., Boston 10, Mass.

RESEARCH INSTITUTE REPORT

Research and Development by Nonprofit Research Institutes and Commercial Laboratories, 1953 which is an 82 page report is available at 50¢ per copy from the Supt., of Documents, Government Printing Office, Washington 25, D.C.

EDUCATIONAL TELEVISION

It costs about $250,000 to build an educational television station and about $150,000 to operate such a station for a year. A station could be built on every one of the 258 reserved channels and operated for a year for a total cost of $103,200,000. That is less than the Federal government spent in 1954 for the price support of beans. And it is less than the government has lost in supporting the price of peanuts.—Leon C. Fletcher, "Is Educational Television Flunking?"—*Educational Screen,* May 1956.

HEALTH

To keep the people of the United States healthy today, it takes: some 210,000 doctors; nearly 7,000 hospitals, with 1½ million beds, admitting 20 million patients a year; about 400,000 nurses; 86,000 dentists; 95,000 pharmacists—plus 300,000 assorted technicians, dietitians, oculists, medical social workers and others.

It costs, for medical care, an average of 5% of the family income. The lower the income, the larger the percentage spent for personal health services.—*Health Information Foundation.*

Honor Roll

Since the publication of our last list, the following sponsored one or more applicants for membership in the Association:

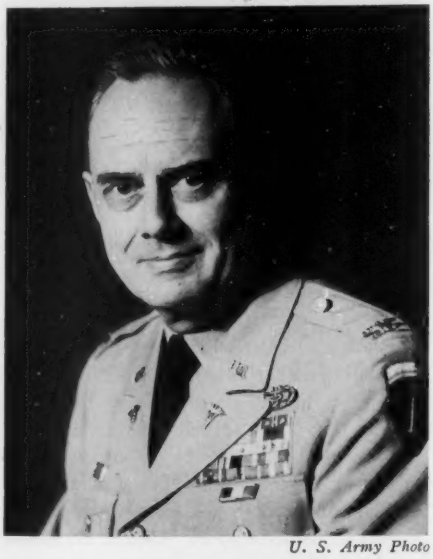
Joe W. Atkinson, D.V.M.
Col. Raymond H. Bunshaw, MC, USA
Cdr. Ellsworth B. Cook, (MSC), USN
Med. Dir. John W. Cronin, USPHS
Rear Adm. W. Dana, (MC), USN
Col. Bryan C. T. Fenton, MC, USA
Lt. Col. Matt A. Gajewski, MC, USAR
Col. Seth Gayle, Jr. MC, USA
Maj. Gen. Alvin L. Gorby, MC, USA
Capt. Keith E. Hanssen, MSC, USA
Nurse Dir. Ruth L. Johnson, USPHS
Diet. Dir. Edith A. Jones, USPHS
Capt. Wm. Cook Livingood, (MC), USN
Cdr. David S. Long, Jr. (DC), USN
Capt. Julian Love, USN, Ret.
Col. Andres G. Oliver, USAF (MC)
Lt. Col. Roy E. Ryner, USAF (VC)
Dr. W. L. Sherman, Sr.
Col. Arthur L. Streeter, USAF (MC)
Asst. Surg. Gen. J. F. Van Ackeren, USPHS
Rear Adm. H. J. Van Peenen, (MC), USN
Col. Herbert Wendelken, MC, NY, NG.

AWARDS

Presented at Honors Night Dinner, 63rd Annual Convention,
Hotel Statler, Washington, D.C., November 14, 1956

WELLCOME AWARD

The Sir Henry Wellcome Medal and Prize is awarded annually through the Association of Military Surgeons of the United States by the Trustees of the Wellcome Foundation in London for the best essay on a military medical subject. The award consists of a Silver Medal, a scroll, and an honorarium of $500. The winner of the 1956 award is Colonel Eugene C. Jacobs, MC, U. S. Army, Commanding Officer of the U. S. Army Hospital, Fort Monroe, Va. The title of his winning essay is "Tuberculosis: Yet an Unconquered Disease." This will be published in the January 1957 issue of MILITARY MEDICINE.



U. S. Army Photo

COL. EUGENE C. JACOBS, MC, USA

Colonel Jacobs is a native of Schenectady, New York, and a resident of River Forest, Illinois. He received his medical degree from the University of Michigan in 1929, and entered the Army in 1934. For three years he was a Japanese prisoner of war in the Philippine Islands, Japan and Manchuria. In 1952 he was an Army delegate to the International Congress of Chest Diseases in Brazil, and in 1956 presented a paper before the International Congress of Chest Diseases in Cologne, Germany.

HONORABLE MENTION in the contest for the Sir Henry Wellcome Medal and Prize was given to Lt. Colonel Joseph V. Conroy, MC, U. S. Army, who is stationed at the U. S. Army Hospital at Fort Dix, New Jersey, for his essay entitled "Acute Ileitis With Ulceration and Perforation Due to Paratyphoid Fever—Report of Eighty-Five Cases." This will be published in the February 1957 issue of MILITARY MEDICINE. Honorable Mention is awarded life membership in the Association of Military Surgeons of the United States.

THE GORGAS MEDAL

The Gorgas Medal is awarded for distinguished work in preventive medicine for our Armed Forces. The award was established by Wyeth Laboratories of Philadelphia in memory of Major General William Crawford Gorgas whose work in preventive medicine made possible the construction of the Panama Canal. This award consists of a Silver Medal, a scroll, and an honorarium of $500.

The winner of the 1956 Gorgas Medal is Captain Robert S. Poos, MC, U. S. Navy, Officer in Charge, U. S. Navy Preventive Medicine Unit No. 6 in Hawaii. He made outstanding contributions relative to poliomyelitis among naval personnel and their dependents in Hawaii and to the use of

U. S. Navy Photo

CAPTAIN ROBERT S. POOS, MC, USN

Salk poliomyelitis vaccine under epidemic conditions.

Captain Poos is a native of Missouri. He received his medical degree from Washington University Medical School in 1934, and was commissioned in the U. S. Navy Medical Corps in 1936. He is a graduate of the De Lamar Institute of Public Health, Columbia University, and the University of California School of Public Health. His specialty is preventive medicine.

THE MAJOR LOUIS LIVINGSTON SEAMAN PRIZE

This prize is made possible through funds left to the Association by Major Louis Livingston Seaman, Surgeon of the First U. S. Volunteers. It is given for some notable article published in MILITARY MEDICINE during the administrative year of the Association. The prize consists of a scroll and an honorarium of $160.

The winner of the 1956 prize is Doctor George M. Lyon, Manager of the Veterans Administration Hospital, Huntington, West Virginia. His article "Radiation Injuries Resulting from Nuclear Explosion and Fallout" was published in the April 1956 issue of MILITARY MEDICINE.

Dr. Lyon is a native of Pennsylvania and received his medical degree from Johns Hopkins University in 1920. In 1916 he had received his B.S. degree in physics from Denison University. In 1956 he was awarded an honorary Doctor of Science degree by Denison University.

During World War I Dr. Lyon served as toxicologist in research in chemical warfare defense at the American University, Washington, D.C. where he established the minimal lethal concentration for the then new war agent, "mustard gas." During World War II he served as an officer in the Navy where part of his service was spent as Safety Adviser to the Commanding General, Manhattan Engineering District and Safety Consultant to the Atomic Bomb Test at Alamogordo, New Mexico (1945). In 1947 Dr. Lyon was appointed Special Assistant for Atomic Medicine, and Chief Radioisotope Section, in the Office of the

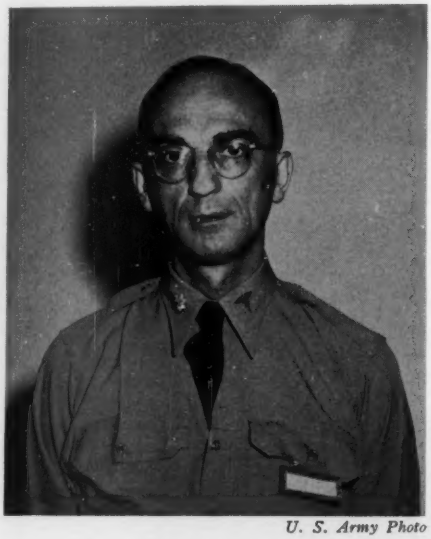
VA Photo

GEORGE M. LYON, B.S., M.D., D.Sc.

Chief Medical Director, Veterans Administration.

THE STITT AWARD

This award is given to the member of the Association of Military Surgeons who has done some outstanding work in the field of antibiotics. The award established in 1954 through the courtesy of Pfizer Laboratories, Brooklyn, New York, consists of life membership in the Association, a metal plaque and an honorarium of $500.



U. S. Army Photo

LT. COL. EDWIN J. PULASKI, MC, USA

The 1956 award has been made to Lt. Colonel Edwin J. Pulaski, MC, U. S. Army, for his contributions in the use of antibiotics in infections and burns. Colonel Pulaski is at present Assistant Chief, Surgical Service, Tripler Army Hospital, Hawaii.

A native of Pennsylvania, Colonel Pulaski received his medical degree from the University of Pennsylvania in 1937. In 1948 he was awarded the D.Sc. degree by Columbia University. He specialized in surgery and in 1944 was called to active duty in the Army, and in 1947 was commissioned in the Regular Army. During his service he has done much research in the field of antibiotics and has written extensively.

THE McLESTER AWARD

This award was established in 1954 by the J. B. Roerig Company Division, Charles Pfizer and Company, Inc., Brooklyn, New York, to honor the memory of Colonel James Somerville McLester, MC, USAR, Birmingham, Alabama. The award is presented to the person who is, or has been, at any time a commissioned officer, or of relative status in the Federal Medical Services, and who has done outstanding work in the field of Nutritional and Dietetics. The award consists of a bronze plaque and an honorarium of $500.

The winner of the 1956 Award is Captain Elinor Pearson, Army Medical Specialist Corps, stationed at the Brooke Army Medical Center, Fort Sam Houston, Texas. She has made outstanding contributions to the research and metabolic studies on severe burn cases.

Captain Pearson is a native of Iowa, her

U. S. Army Photo

CAPT. ELINOR PEARSON, AMSC

home being in Perry, Iowa. She earned her B.S. degree at Wheaton College, Wheaton, Illinois (1937) and her M.S. degree at Iowa State College (1949). She was an instructor and research assistant at the Iowa State College, and a research associate at the University of Tennessee, and an associate home economist at the Georgia Experiment Station. She has been associated with the Army as a dietitian in both a civilian and commissioned status since 1941 except for a few years after World War II.

THE FOUNDERS MEDAL

The Founders Medal is awarded by the Executive Council of the Association of Military Surgeons of the United States to members of the Association for meritorious service in the field of military medicine. The recipients of this medal and the scroll which accompanies the medal for 1956 are:

Major General George E. Armstrong, U. S. Army, Retired, former Surgeon General of the Army (1951-1955), now Director, New York University-Bellevue Medical Center of New York University.

U. S. Army Photo

MAJ. GEN. GEORGE E. ARMSTRONG, USA, RET.

U. S. Navy Photo

CAPT. WALTON L. JONES, MC, USN

Captain Walton L. Jones, MC, U. S. Navy, Bureau of Medicine and Surgery, Department of the Navy, Washington, D.C.

Captain Eugene V. Jobe, MC, U. S. Navy, Bureau of Medicine and Surgery, Department of the Navy, Washington, D.C.

U. S. Navy Photo

CAPT. EUGENE V. JOBE, MC, USN

Change in Constitution Proposed

To be acted on at the 63rd Annual Convention, November 12-14, 1956

AT THE business meeting of the 62nd Annual Convention of the Association of Military Surgeons of the United States, held November 9, 1955, the following resolution was passed:

"WHEREAS, Membership eligibility in the Association of Military Surgeons of the United States as now defined in the Constitution and By-Laws does not recognize personnel identified with either the Civil Defense Administration or Atomic Energy Commission,

"WHEREAS, These two agencies are attracting personnel in increasing numbers whose eligibility would not be questioned if they represented one of the recognized services,

"BE IT RESOLVED, That proper steps be taken to amend the Constitution and By-Laws so as to include personnel from these services who are otherwise eligible."

In accordance with the provisions of the Constitution of the Association the president appointed a committee to study the resolution and prepare the necessary amendment. The committee presented the following proposed change to Section 4, Article III of the Constitution of the Association:

"The Secretary of Defense; the Secretary of the Department of Health, Education, and Welfare; the Secretary of the Army; the Secretary of the Navy; the Secretary of Air Force; and the Administrator of Veterans Affairs; *the Chairman, Atomic Energy Commission; and the Director, Federal Civil Defense Administration;* in conformity with the Act under which this Constitution is adopted, shall be ex officio members of the Association, while holding their respective offices."

After considerable discussion of the proposed change the Executive Council declared its opposition to any change in the constitution. It was the consensus of opinion that eligibility for membership already covers a wide field of interests including a large majority of the medical personnel of the Civil Defense Administration, and the Atomic Energy Commission, and any changes in the constitution are unnecessary.

INFORMATION FOR AUTHORS

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REPRINTS: must be ordered when galley proof is returned by the author to the editor.

ADDRESS: Send manuscripts to the Editor, MILITARY MEDICINE, Suite 718, 1726 Eye Street, N.W., Washington 6, D.C.

OBITUARIES

Lt. Col. Eugene Davidoff, U. S. Army, Res.

Eugene Davidoff, Lieutenant Colonel, U. S. Army, Reserve, died at Schenectady, New York, July 23 at the age of 55.

Colonel Davidoff graduated in 1927 from the State University of Iowa College of Medicine. He specialized in the field of neuropsychiatry and had been chief of psychiatry at the Ellis Hospital, Schenectady. Formerly he had directed the Veterans Administrations' program in neuropsychiatry in New York. His address given on the records of the Association was 17 Sunnyside Road, Scotia, New York.

Lt. Col. Oliver J. Christiansen, U. S. Army, Ret.

Oliver James Christiansen, Lieutenant Colonel, U. S. Army, Retired, died at the Wadsworth General Hospital, Los Angeles, Calif., on August 20 at the age of 63.

Colonel Christiansen was a native of California. He received his degree of Doctor of Dental Surgery from the University of California in 1916, and was commissioned in the Regular Army Dental Corps in 1917. During World War I he served with the American Expeditionary Forces in Europe and during World War II was at Camp Barkley, Texas until his retirement by reason of physical disability on May 31, 1942. Colonel Christiansen was a member of the Association of Military Surgeons of the United States and a member of the National Rifle Association of America.

He is survived by his widow, Hazel L. Christiansen, of 2028 Chivers St., San Fernando, Calif., and a son, Oliver James, Jr., of Lancaster, Calif.

Interment was at Los Angeles, Calif.

Maj. Gen. Robert E. Noble, U. S. Army, Ret.

Robert E. Noble, Major General, U. S. Army, Retired, died at the U. S. Army Hospital, Fort McClellan, Alabama, on September 18 at the age of 85.

General Noble was a native of Georgia. He received his medical degree from Columbia University College of Medicine in 1899. He entered the Army one year later. From 1907-1914 he was stationed in the Panama Canal Zone where he was associated with General Gorgas in that monumental task of yellow fever eradication, a task which was successfully accomplished and played such a great part in the completion of the Panama Canal. He retired from the Army in 1925 and made his home in Anniston, Alabama.

He is survived by his widow, Mrs. Ella L. Noble.

Interment was at Anniston, Alabama.

Brig. Gen. William R. Dear, U. S. Army, Ret.

William Richard Dear, Brigadier General, U. S. Army, Retired, died at Walter Reed Army Hospital on September 7 at the age of 72.

General Dear was a native of Virginia. He received his medical degree from the University of Pennsylvania School of Medicine in 1906, and was commissioned in the Army Medical Corps in 1908. He was Honor

Graduate from the Army Medical School in 1909. In 1931 he was awarded the Doctor of Public Health degree by the University of Pennsylvania.

Foreign duty for General Dear included the Philippines, China, and Russia, the latter assignment being with the Hoover Relief Mission (1921-23). During World War II General Dear was in charge of the Medical Replacement Center at Camp Lee and later Camp Pickett, Va. In 1943, he was assigned as Commanding General of Northington General Hospital at Tuscaloosa, Ala. He remained there until 1946 when he retired from the Army.

He is survived by his widow, Mrs. Greta Dear, 2311 Connecticut Ave., N.W., Washington, D.C.; one son, Lt. Colonel H. B. Dear, MC, U. S. Army, now on duty in Brazil; and a daughter, Mrs. Gordon C. Dewey.

Interment was at Arlington National Cemetery.

LCdr. Carl E. Reynolds, U. S. Navy, Ret.

Carl E. Reynolds, Lieutenant Commander, U. S. Navy, Retired, died at Grants Pass, Oregon, September 9 at the age of 72.

Commander Reynolds was born in Woburn, Mass., on June 29, 1884. He graduated from Tufts College in 1907. He entered the Navy in 1918 as a Lieutenant (junior grade) in the Dental Corps. He retired from active service in 1944.

Commander Reynolds is survived by his wife, Mrs. Louise Reynolds, San Jacinto, Calif.

Interment was at Fort Rosecrans National Cemetery, San Diego, Calif.

BOOK REVIEWS

DISEASES OF THE SKIN. 11th Ed. By Richard L. Sutton, Jr., A.M., M.D., F.R.S. (Edin)., Chairman, Department of Dermatology, University of Kansas Medical Center. 1479 pages, 1972 illustrations. The C. V. Mosby Company, St. Louis. 1956. Price $29.50.

In creating this variant of a hardy perennial among American textbooks on dermatology the younger Sutton has performed as skillful a feat of pruning and grafting as was ever planned by a Burbank. The metamorphosis of an aging, ponderous volume whose last complete revision occurred before World War II into a completely modern and more compact version was a task of herculean proportions, which only the dedication of filial piety could have encompassed.

This reviewer spent several hours in comparing the present edition with its predecessor of 1939. It is apparent that not a single page has escaped unaltered. Through the elimination of redundant statements and smaller paragraphs the style has been improved and is now vigorous and clear. Obsolete, confusing nomenclature, and other terms of purely antiquarian interest have been rigorously excluded. For a moment I thought the editorial axe had fallen on old von Recklinghausen, although later he appeared in the index safe under the Rs. Numerous photographs and microphotographs of high quality have been added to replace inferior cuts; some of the older illustrations were pared down and rearranged to accommodate more cuts per page. An ingenious method of juxtaposing bibliographical references with subject matter should serve to stimulate additional reading. A smaller but quite legible type has been used for lengthy discussions considered of minor importance to the general reader. As a result of these changes and by the use of an expanded line of type it has proved possible to eliminate about one hundred pages, thus making the book less bulky.

Although we are dealing with what is virtually a new work, readers of the earlier editions will find many of the familiar features which have helped to maintain Sutton's popularity through the years. The encyclopedic nature permits thorough exploration of controversial subjects. The author almost invariably adds his own opinion, without reservations, even when this differs from weighty authority. The chapter on "Psychosomatic Aspects of Dermatology," to cite an example, contains a generous and fair résumé of recent interest in this field, followed by a frank statement of the author's own skeptical but openminded attitude. A few weeks ago I had the opportunity of hearing Dr. Sutton address a group of dermatologists and general practitioners on the important but somewhat hackneyed subject of cutaneous cancer. The talk was anything but dull, being enlivened by candid and hard-hitting statements of the speaker's own position on treatment. Dr. Sutton likes the knife for skin cancers wherever practical, and abhors the curette. In reading the book we find the same elements of clarity and explicitness in all the important sections on diagnosis and therapy. Our old friend in new garb can be recommended highly as an accurate and reliable companion in the sometimes confusing maze of dermatology.

LT. COL. MORRIS H. SAFFRON,
MC, USAR

PRECIS D'EPIDEMIOLOGIE ET PROPHYLAXIE DES GRANDES ENDEMIES TROPICALES. By V. Reynes. 418 Pages. Masson et Cie, Paris, France. 1955. Price 2.800 Fr.

This is the third edition of a volume that is enjoying wide circulation in France and her Territories. The author is a doctor in the French Colonial Army and holds the title of Professeur Agrégé, an academic rank conferred on one who has passed examinations higher than those leading to a doctorate. The many years of experience the author has had in dealing with tropical illnesses are reflected in the fundamental, up-to-date concepts elaborated upon throughout the text.

The subject matter stresses epidemiology and prophylaxis primarily. The text is divided into six sections dealing in turn with General Epidemiology, Diseases Transmitted via the Naso-Pharyngeal Discharges, Diseases of Fecal Origin, Diseases Transmitted by the Arthropods, The Helminthic Group,

and the Varied Group, such as Beri-Beri, Leprosy, etc. Three additional chapters have been included in this newest edition which deal with Poliomyelitis, the Leptospiral Diseases, and the Epidemiological Role of the Rat.

The unique presentation of the subject matter in semi-outline form plus brevity and attention to detail enables the busy reader to derive a vast amount of information in a minimal period of time. An excellent and instructive volume dealing with a most important category of diseases the control of which assumes greater significance in view of our world-wide military and economic commitments.

LT. COL. FRANK J. VITA, MC, USA

MEDITATION ON MEDICINE AND MEDICAL EDUCATION, PAST AND PRESENT. By I. Snapper, M.D. 138 pages. Grune & Stratton, New York and London. 1956. Price $3.75.

Born in the Netherlands and Professor of Medicine for many years at the University of Amsterdam, the author, quite naturally, has turned his attention to certain phases of Dutch medical history. Of great interest is the account of medical, pharmaceutical, and nursing practice in colonial New York. The contrast of the low maternal death rate in the rural areas with the terrible mortality in European hospitals is very apt and the reasons for the difference clearly given.

The greater part of the book is devoted to Boerhaave and his influence both on his contemporaries and on the future development of medicine, particularly in the United States. The author shows how Boerhaave revived clinical teaching, and with Sydenham, brought back the Hippocratic study of the natural history of disease and the physician's role as an assistant to nature. The last chapter deals largely with medical education and contains much that is worthy of serious consideration by all medical men. Dr. Snapper contrasts European and American teaching methods in medicine; outlines the rise and decline of diploma mills in this country; and the conflict between clinical teaching and research. Much of the criticism of the medical profession today is apparently due to the failure of the medical schools to follow the Hippocratic concept of the individual patient as the goal of all medical thought and action. The production line non-personal contacts; the dependence on laboratory and technical procedures; and the emphasis on hospital treatment has thrown a sort of iron curtain between doctor and patient. The author has no easy solution for the problems of medical education but does indicate some of the steps to be taken. Altogether this is an excellent and provocative little book.

CAPT. LOUIS H. RODDIS, USN, RET.

TREATMENT OF THE CHILD IN EMOTIONAL CONFLICT. By Hyman S. Lippman, M.D., Clinical Professor, Dep't. of Psychiatry and Dep't. of Pediatrics, University of Minnesota Medical School. 298 pages. The Blakiston Division, McGraw-Hill Book Company, Inc. New York, Toronto, London. 1956. Price $6.00.

The author of this review was associated with Dr. Lippman at the Institute for Child Guidance in New York City in 1928 and was impressed by Dr. Lippman's sincerity in the handling of the children. At that time Dr. Lippman was the pediatrician associated with the Institute, and it was gratifying to know that he later took up his psychiatric training and became Director of the Amherst H. Wilder Clinic for the treatment of children in Minneapolis.

He well states that "the child-guidance clinic can provide many different methods of treatment. In working together with children and their parents, the members of a clinic team quickly lose any preconceived idea that the principles upon which a particular therapy is based are the best. Faced with the suffering of the children and the anxiety of the parents, the members of the staff unite to develop methods of lessening unhappiness as quickly as possible. Together they bend their efforts toward helping the child to help himself. The best features of each discipline come into practice in the interests of those they serve."

Throughout this book Dr. Lippman has presented a number of case studies which well illustrate the points that he tries to bring out. At the conclusion of this volume he summarizes his entire thesis: "Preventing the development of conflict in children is of greatest importance. Prevention as prescribed in this book involves putting into operation practices which clinical experience has proved to be effective. The most practical method of preventing emotional maladjustment is through eliminating early in life those factors which are known to produce later maladjustment.

"Many children who are emotionally conflicted cannot respond to methods of therapy available in the child-guidance clinic. Their disturbances are based on conflict repressed

in their unconscious. Nothing short of child analysis will cure these children.

"Some children cannot be helped at all; this may be due to factors within the child or within the parents. The child who steadfastly refuses to accept treatment cannot be helped. Parents who have an unconscious need to interfere with therapy prevent the child's responding unless they learn to recognize their unconscious sabotage. Collaborative therapy involving psychoanalytic treatment of the child and the parents may be the only effective method with some acting-out problems of children.

"Effective treatment of an emotionally conflicted child should lessen anxiety, insecurity, and inhibition, help him to deal with reality problems and relate himself to other children and members of his family, provide him with energy to enjoy work and play, and help him to accept himself as a capable and love-worthy child. Therapy should reduce the problems that have made life less pleasant for him and his parents.

"Therapy rarely continues until all this is accomplished. When the findings indicate that development is in the direction of emotional growth and lessening of conflict, one may assume that the necessary strengths have been provided and the child and parents can manage through their own efforts."

Although Dr. Lippman's approach to the subject is entirely Freudian, this book can well be recommended to anyone who wishes to understand the objectives of child guidance in the prevention of adult maladjustment.

CDR. JAMES L. MCCARTNEY, USNR, RET.

ORAL CANCER AND TUMORS OF THE JAWS. By George S. Sharp, M.D., F.A.C.S., Professor of Pathology, School of Dentistry, University of Southern California; Weldon K. Bullock, M.S., M.Sc., Associate Clinical Professor of Pathology, School of Medicine, University of Southern California; and John W. Hazlet, D.D.S., Lecturer, Oral Tumor Pathology, School of Dentistry, University of Southern California. 561 pages, illustrated. The Blakiston Division, McGraw-Hill Book Company, Inc., New York, Toronto, London. 1956. Price $15.00.

The purpose of this book is to assist the doctor or dentist in the early diagnosis of cancer of the mouth. The practitioner to whom the patient first reports has the responsibility for recognizing cancer in its earliest stages and for instituting prompt treatment without temporizing. He must know the signs and symptoms which indicate possible cancer and he must know the steps to take in establishing a definitive diagnosis. This book contains that information.

The presentation of the picture of cancer of the mouth involves also the differential diagnosis of benign lesions so that his volume is a text book of diseases of the mouth and jaws and is not limited to tumors. The clinical appearance of lesions is emphasized and is well illustrated by numerous black and white clinical photographs and reproductions of x-ray films. The photographs of lesions are excellent and should be of great assistance in making a clinical diagnosis. The roentgenographic characteristics are presented whenever indicated. The histopathology of various lesions is discussed but is not illustrated. Prognosis and treatment is included in the discussion of the various lesions as is also etiology.

This book is for the practitioner, for the man who first sees the patient rather than for the surgeon or the pathologist but it will be of interest to all who are concerned with the recognition of tumors of the mouth and jaws.

COL. HUGH R. GILMORE, JR., USA, RET.

A TEXTBOOK OF OPERATIVE DENTISTRY. 4th Edition. By William H. O. McGehee, D.D.S., M.D., F.A.C.D., Formerly Professor of Operative Dentistry, New York University College of Dentistry; Harry A. True, D.D.S., F.A.C.D., Professor of Operative Dentistry, College of Physicians and Surgeons of San Francisco, A School of Dentistry; E. Frank Inskipp, B.S., D.D.S., F.A.C.D., Late Dean, College of Physicians and Surgeons of San Francisco, A School of Dentistry, and twenty other noted contributors. 720 pages —Illustrated, The Blakiston Division of the McGraw-Hill Book Company, Inc., New York, Toronto, London. 1956. Price $14.00.

This monumental book contains a wealth of knowledge indispensable for undergraduate study and of great value to the postgraduate student and the practicing dentist as a constant reference source.

It's main value lies in its great detail set down in simple terms which can easily be studied and followed. It treats each detail of procedure with the care and precision expected of men of the highest caliber who

have made dentistry their life work and love every phase of it.

This textbook is not at all new to young and old students of dentistry but in this its fourth edition it goes to even greater lengths than its predecessors. The new chapter on accuracy with speed touches a bit too briefly upon the technic of high speed procedures and the psychological advantages to both patient and operator. Also the various means and methods of gaining high speeds are not as fully covered as possible. It is hoped that the next edition will more fully cover these highly important procedures.

The other new section of pedodontics is as full and comprehensive as possible. It is a complete study in the subject and could be used as a complete text for children's operative dental care.

The section on endodontia is also excellent. The diagnosis of each type of pulpal disturbance is especially well presented and the subsequent treatment procedures are carried out to perfection.

This text can be a real boon to the dental practitioner who needs a refresher in his operative techniques and details. Its reading must make one a better dentist.

LT. COL. GEORGE G. TRATTNER,
DC, USAR

LES BRONCHOPATHIES POST-OPERATORIES ET LEUR TRAITEMENT. By Pierre Mounier-Kuhn. 170 pages, illustrated. Masson & Co., Paris, France. 1956. Price 1,200 Fr. (In French)

This monograph is divided into two parts. The first part deals with etiology, pathological anatomy, pathogenesis and clinical study and treatment of the syndrome. The second part consists in a review of sixty case histories.

The type of operation is of great etiological importance. Thoracic surgery ranks first in producing the bronchus for operative bronchopathies. Orthopedic surgery gives the least complications, except when performed on new-borns for congenital malformations. The position of the patient during the operation has some bearing. The role of the anesthesia and pre-medications are discussed.

The authors blame intravenous infusions of large amounts of fluids for being the cause of pulmonary edema. Potassium deficiency is given as one of the causes of the paralysis of the ciliary system of the bronchial tree. According to the authors, a blood potassium determination should be done on every post-operative case presenting abnormal bronchial secretions.

They believe that the broncho-pulmonary complications are only one episode of the so-called post-operative disease. The mucous plug originally described by Chevalier Jackson, is, according to the authors, only a consequence of the reflex pathological hyper-secretion of the bronchial mucosa.

The authors have brought out two main facts. One is, the secretion is not only overabundant, but it is also pathological in composition. The second is the difficulty of the elimination of the secretion, which in turn produces the plugging of the bronchial tree.

The syndrome called *post-operative bronchopathy* is first and foremost characterized by progressive functional difficulties. In a patient who has been operated one or two days before, the surgeon notes the progressive and rapid appearance of a dyspnea, which, although not very impressive in the beginning, becomes more and more severe, and is accompanied by a hacking, non-productive cough. The extremities become cold and cyanotic, and the patient is covered with profuse perspiration. At the same time, the respiration becomes noisy, and progresses to a laryngotracheal gurgling. The temperature and the pulse rise. X-ray of the chest could give, at this time, very valuable information, but these are patients who have been recently operated on, and whom one hesitates to mobilize.

This characteristic picture is not the only one, and several clinical types have been described: (1) The flooding of the tracheobronchial tree; (2) Pulmonary atelectasis; (3) Post-operative bronchitis; (4) Post-operative infarct and pulmonary abscess; (5) Complicated post-operative bronchopathies.

According to the authors, prevention is the most important part of the treatment. Before each major operation, and especially before a thoracic operation, the antibiotics, atropine, postural drainage, aerosal, etc., should be used.

During the operation, pre-medication, the position of the patient, the anesthetic, and the surgery itself, are of great importance. In the post-operative period, the recovery room with specialized personnel and special equipment is a must. When the syndrome has set in, nothing is as important as bronchoscopy with aspiration. The bronchoscopy treatment should be repeated many times

until the result is obtained. All the other methods, chemotherapy, and antibiotic therapy are only secondary to the bronchoscopy.

The book is well-written, gives a wealth of original material, and should be of great value not only to the surgeon and bronchoscopist, but also to any medical man who follows the post-operative course of his patient. There is an excellent bibliography, but no index.

MAJOR J. B. BICKEL, MC, USAR

THE HABIT OF TOBACCO SMOKING. By W. Koskowski, M.D., Alexandria, Egypt. 292 pages, illustrated. John de Graff, Inc., New York. 1955. Price $5.00.

This is a timely book written by a professor on the Faculty of Medicine in the Alexandria University, Egypt.

Two major sections comprise this work. The first and shorter part (92 pages) consists of a historical review. Here the author outlines the discovery of tobacco, legends and myths about its origin, the introduction of tobacco into various places, its use in magic, in religious ceremonies and in primitive medicine and finally a concluding chapter on 19th century medical opinions about the influence of tobacco on the human body.

The second and longer part of the book is entitled "The Action of Tobacco and Its Compounds on the Human Organism." After a preliminary chapter on the chemical composition of tobacco and tobacco smoke, the author takes up the question of the effects of smoking on various organ systems (cardiovascular, respiratory, digestive, nervous, etc.).

Of particular interest of course is the chapter on tobacco smoking and malignant tumors. The author leans toward the idea that there is an etiologic relation between smoking and the incidence of malignancies.

Not all readers will agree with the author in all of his conclusions; nevertheless this book can be recommended as an interesting and useful reference work on an important subject.

MORRIS C. LEIKIND

MILITARY JUSTICE IN THE ARMED FORCES OF THE UNITED STATES. By Robinson O. Everett, Former Commissioner of the United States Court of Military Appeals. 338 pages. Military Service Publishing Company, Harrisburg. 1956. Price $5.00.

Drawing upon his varied experience, both in and out of uniform, Mr. Everett has compiled in his book a variety of informative material, pertaining to military justice and related matters, which usually is not available to the previously uninformed until after years of practical experience. Except in those fields which have not as yet been fully explored and in which therefore the ultimate ruling is speculative, his references and legal precedents appear to be factually accurate. For the neophyte judge advocate, Mr. Everett's book will furnish a ready source of practical information together with references to the legal bases from which his conclusions are drawn. The layman will find in this book an interesting discussion of the legal protections and safeguards which have been furnished military personnel accused of crimes through congressional acts and the interpretive decisions of those acts by the courts.

CAMPBELL'S OPERATIVE ORTHOPAEDICS. 3rd Edition. Vol. I & II. By J. S. Speed, M.D., Editor; and Robert A. Knight, M.D., Associate Editor. 17 Contributors. 2124 pages, 1323 illustrations. The C. V. Mosby Company, St. Louis. 1956. Price $40.

Drs. Speed and Knight should be congratulated for their most excellent contribution and summary of the important features of operative orthopaedic surgery. The two author-editors have thoroughly covered the surgical field of orthopaedic surgery. The important phases of operative orthopaedics have been excellently recorded. The mature observations and the mature judgment of the contributors are included in the introduction and further discussion of the various phases of this field.

Volume I has an excellent discussion of surgical physiology. Pre-operative and post-operative care are illustrated and their importance beautifully emphasized. Orthopaedic apparatus and surgical technique with the very finest discussion and illustration of surgical approaches gives the reader a very fine basis of this surgical specialty.

The surgical aspect of acute infective arthritis, wounds of joints and traumatic affections of joints has been brought up to date. Dislocations, fractures, including malunited fractures, delayed and non-union of fractures are excellently handled and contain the worthwhile contributions from the literature. It is apparent that the author-editors have made an exhaustive study of the present day literature and have gone to

great pains to include the worthwhile contents. Peripheral nerve injuries and amputations are excellently covered.

Volume II, containing approximately 1,000 pages, covers the affectations of joints, tuberculosis, arthrodesis, ankylosis and deformity, arthroplasty, affections of bones, tumors of bones, joints and soft tissues, muscles, tendons, and tendon sheaths, fascia, bursa, lymphatic system; also, the surgical aspects of anterior poliomyelitis, affectations of the nervous system, static or postural affections and congenital anomalies.

The many fields included in the foregoing discussion indicate how thoroughly the literature has been covered by this most excellent presentation.

These two volumes are worthy successors to Editions I and II of the famous Campbell's Orthopaedic Surgery. They are a worthy memorial to Dr. Campbell. They are a must for every practitioner of medicine who does either the operative or medical aspects of the field of orthopaedic surgery.

Wm. Compere Basom, M.D.

Diseases of the Chest. By H. Corwin Hinshaw, M.D., Ph.D., Clinical Professor of Medicine, Stanford University School of Medicine; and L. Henry Garland, M.D., B.Ch., Clinical Professor of Radiology, Stanford University School of Medicine. 727 pages, illustrated. W. B. Saunders Company, Philadelphia and London. 1956. Price $15.00.

This new volume affords the clinician and student an up-to-date text with which to study recent developments and treatment of thoracic disorders. The co-authors are two eminent faculty members of Stanford University School of Medicine. The collaboration of an internist and a radiologist in preparing a text enables their concepts to be well organized. Surgical treatment is necessarily mentioned in generalities.

There are forty chapters. Included are the subjects of diagnostic procedures, segmental anatomy, pulmonary function, and foreign bodies. Sarcoidosis, coccidioidomycosis and other fungous infections are adequately covered. There is an excellent presentation of the pulmonary diseases of occupational origin. Another section covers the subject of tuberculosis in a manner to be recommended. Newer laboratory methods are carefully appraised.

The bibliography is current and well chosen and provides references listing more extensive sources of material. The roentgenograms are reproduced with a clarity not matched in many texts and the clear print and chapter outlines make for ease in reading.

R. N. Shelley, M.D.

Selected Papers of Joseph W. Mountin, M.D. Editorial Committee: Thomas Parran, M.D.; Harry S. Mustard, M.D.; Dean A. Clark, M.D. 356 pages. Joseph W. Mountin Memorial Committee, 1956. Distributed by American Public Health Association. New York. Price $5.00.

Dr. Joseph W. Mountin was a distinguished officer of the United States Public Health Service for 35 years, from 1917 until his death in 1952. During this long career, which began in a small rural district in Missouri and ended as director of the Bureau of State Services of the Public Health Service, he was responsible for 163 reported speeches, articles, and papers on a variety of public health topics. Of these, 48 of the most significant have been assembled in this volume by an editorial committee consisting of Drs. Thomas Parran, Harry S. Mustard, and Dean A. Clark. These papers are not arranged chronologically, but by subjects, and cover, always forcefully and sometimes brilliantly, the scope and content, the organization, and the administration of public health services. They are, as the editorial committee points out in the Preface, challenging expositions of problems and principles in modern public health, and as such they should be of interest and value not only to the many friends and colleagues of Dr. Mountin, but to public health workers generally. The book itself is very well printed. It has no index. It was made possible by contributions, the list of contributors appearing in the back.

Although no address is given for the Memorial Committee, the reviewer is informed that the book can be obtained from the American Public Health Association, 1790 Broadway, New York 19, N.Y.

Col. James A. Tobey, USA, Ret.

NEW BOOKS

Proceedings, World Congress of Anesthesiologists, Scheveningen, The Netherlands, September 5-10, 1955. Burgess Publishing Co., Minneapolis 15, Minn.

Cosmetics, Their Principles and Practices, by Ralph G. Harry. Chemical Publishing Co., New York, N.Y. Price $17.00.

Clinical Urology for General Practice, by Justin J. Cordonnier, M.D. The C. V. Mosby Co., St. Louis, Mo. Price $6.75.

Studies in Topectomy, edited by Nolan D. C. Lewis, M.D., Carney Landis, Ph.D., D.Sc. and H. E. King, Ph.D. Grune & Stratton, New York, N.Y. Price $6.75.

Venous Return, by Gerhard A. Brecher, M.D. Grune & Stratton, New York, N.Y. Price $6.75.

Psychopathy and Delinquency, by William McCord, M.D. and Joan McCord, Ed.M. Grune & Stratton, New York, N.Y. Price $6.50.

J.A.M.A. Clinical Abstracts of Diagnosis and Treatment. Published with the Approval of the Board of Trustees, American Medical Association. Intercontinental Medical Book Corp., with Grune & Stratton, Inc. New York and London. Price $5.50.

The Training of Sanitary Engineers, by Milivoj Petrik, Ing., M.S., WHO Monograph Series No. 32. Columbia University Press, New York, N.Y. Price $4.00.

Management of Emotional Problems in Medical Practice, edited by Samuel Liebman, J. B. Lippincott Co., Philadelphia, Pa. Price $5.00.

Surgery for General Practice, by Victor Richards, M.D. The C. V. Mosby Co., St. Louis, Mo. Price $17.50.

Franz Joseph Gall, Inventor of Phrenology and His Collection, by E. H. Ackerknecht, M.D. and H. V. Vallois, M.D. 86 pages (paper cover). Univ. of Wis. Medical School, Madison, Wis. Price $1.50.

Industrial Vision, by H. W. Hofstetter, Ph.D. 187 pages, illustrated. Chilton Publications, Philadelphia, Pa. Price $10.00.

Remington's Practice of Pharmacy, edited by Eric W. Martin, E. Fullerton Cook, Mack Publishing Co., Easton, Pa. Price $20.00.

The Doctor in Personal Injury Cases, by Harold A. Liebenson, LL.B. The Year Book Publishers, Inc., Chicago, Ill. Price $4.00.

Roentgen Signs in Clinical Diagnosis, by Isadore Meschen, M.C., M.D. with the assistance of R. M. F. Farrer-Meschen, M.B., B.S. W. B. Saunders Co., Philadelphia and London. Price $20.00.

Dermatology, by Donald M. Pillsbury, M.Z., D.Sc. (Hon), M.D., Walter B. Shelley, M.D., Ph.D., Alber M. Kligman, M.D., Ph.D. W. B. Saunders Co., Philadelphia and London. Price $20.00.

Introductory Psychosomatic Dentistry, by John H. Manhold, Jr., D.M.D., M.A. Appleton-Century-Crofts, Inc., New York, N.Y. Price $5.00.

New Bases of Electrocardiography, by Demetrio Sodi-Pallares, M.D. and Royall M. Calder, M.D. The C. V. Mosby Co., St. Louis, Mo. Price $18.50.

Practitioners' Conferences. Held at The New York Hospital-Cornell Medical Center, Vol. 4. Edited by Claude E. Forkner, M.D., F.A.C.P. Appleton-Century-Crofts, Inc., New York, N.Y.

Ageing in Transient Tissues, Ciba Foundation Colloquia on Ageing, Vol. 2. Editors G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch. and Elaine C. P. Millar, A.G.W.C., A.R.I.C. Little, Brown & Co., Boston, Mass. Price $6.75.

Internal Secretion of the Pancreas, Ciba Foundation Colloquia on Endocrinology, Vol. IX. Editors G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Elaine C. P. Millar, A.G.W.C., A.R.I.C. Little, Brown & Co., Boston, Mass. Price $7.00.

Today's Industrial Nurse and Her Job, by Erna Barschak, Ph.D. G. P. Putnam's Sons, New York, N.Y. Price $3.20.

Head Injuries and Their Management, by Francis Asbury Echlin, M.D. J. B. Lippincott Co., Philadelphia, Pa. Price $3.00.

Observations on Krebiozen in the Management of Cancer, by A. G. Ivy, Ph.D., M.D., John F. Pick, S.B., M.M., M.D., and W. F. P. Phillips, M.D. Henry Regnery Co., Chicago, Ill. Price $2.50.

Dynamic Psychiatry in Simple Terms, by Robert R. Mezer, M.D. Springer Publishing Co., Inc., New York, N.Y. Price $2.50.

Books Books

A BOOK will make an ideal gift for Christmas.

One of the services offered by your Association is the book service. All you have to do is to list the books wanted with the name of the author and publisher. Send us the list and we will place the order with the individual publisher. That will save you time.

The books listed in the preceding pages may help you in your selection. You are not limited to these in your selection, of course. See former issues of *Military Medicine* for other books. You may even have one in mind that is not listed.

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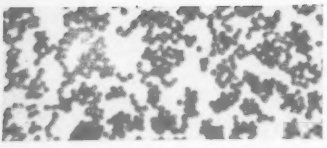

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